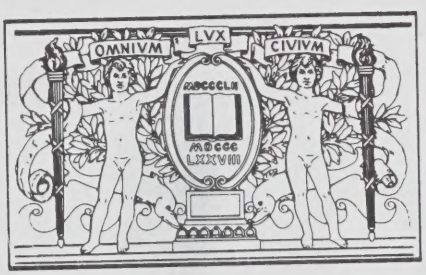

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Young Men in Boston 2001:
A Health Profile

Suggested Citation
Young Men in Boston 2001: A Health Profile
Boston Public Health Commission
Research Office
Boston, Massachusetts
2001

ACKNOWLEDGMENTS

The following persons contributed significantly to this report: John Auerbach, MBA, Executive Director, Barbara Ferrer, PhD, MPH, Deputy Director, and John Rich, MD, MPH, Medical Director, members of the Executive Office of the Boston Public Health Commission; Stefan Battle, MSW, Jabes Rojas, MSc, Program Manager, Men's Health; Sara Helen Ayanian, BA, Research Associate/Report Production Assistant, Dwight Cathcart, PhD, Senior Technical Writer and Editor, May R. Yamate, MS, Epidemiologist, Stefanie Thomas, temporary production assistant, Phyllis D. Sims, MS, Senior Research Associate/Reports Coordinator, members of the Reports Unit; and Mary Ostrem, DrPH, Director, Research Office.

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HOW TO READ AND USE

Public Health Work in Boston

The Boston Public Health Commission is committed to reducing morbidity and mortality and to improving the health of all Boston residents. The Commission's publications can be used to identify successes that can be built upon and areas of difficulty that need more attention, and the Commission embraces the opportunity to work collaboratively with the community to improve the health of all of the city's residents.

Data Issues

The most recent Boston data available from most sources is from 1999. However, the time span reported for the health indicators included in this report vary. Mortality data in this report are based on census tracts; data on hospitalization, STDs, and HIV/AIDS are based on ZIP codes.

Rates are calculated using the Boston population as reported in the 1990 US census, since the 2000 US census is only now beginning to be published. Rates provided by other sources may use different population bases. Data in this report are presented using numbers, percentages, and age-specific and age-adjusted rates. The Technical Notes provide details on these and related issues.

A Warning on Mortality Data

Because of changes in the way data are collected and categorized, made by international and national health organizations, some mortality rates presented in this report cannot be compared to mortality rates presented in the *Health of Boston 2001*, recently published.

Race and Ethnicity

There are limitations associated with race and ethnicity data. National, state, and local health data sources usually make available data for only a few large racial and ethnic groups, and the classifications they use are not always consistent with other sources; caution should be used in comparing racial and ethnic data from different sources. The categories used in *Young Men in Boston 2001: A Health Profile* are non-Hispanic White ("White"), non-Hispanic Black ("Black"), Asian/Pacific Islander ("Asian"), and Hispanic ("Hispanic"). All data used in this report except those taken from death certificates are self-reported. When population data are needed to calculate age-specific rates and age-adjusted rates, the Modified Age-Race-Sex file for Boston census tracts is used in order to enable counting Hispanics as a distinct group, separate from Whites, Blacks, and Asian/Pacific Islanders.

In considering the racial and ethnic designations used in this report for Boston-specific data, several things should be kept in mind: (1) The concept of race has different meanings in different cultures. (2) Race is not a biological, but rather a social construction. (3) The meanings of racial designations—White, Black, Asian/Pacific Islander—are subject to historical, cultural, and political forces. (4) Finally, racial designations can be notably inaccurate in describing what they are called upon to describe. The term Black, for example, includes a variety of people who would describe themselves as African-American, African, Caribbean, or Haitian.

In the charts which present data by race and ethnicity or in the text which discusses health problems among racial and ethnic populations, it should be kept in mind that, as the CDC has said, "race and ethnicity are not risk factors [for disease]—they are markers used to better understand risk factors." Race is often a proxy for such factors as socioeconomic status, inadequate access to health care, and racial discrimination. Information on race and ethnicity is included in this report because it can assist public health efforts to recognize disparities between groups for a variety of health outcomes.

Racial Designations and the 2000 Census

The racial designations, or categories, used in the 2000 census differ from the designations used in the 1990 census and in the census documents based on it, like the 1990 Modified Age-Race-Sex File for Boston census tracts. Consequently, rates for racial and ethnic groups in this report cannot be compared to rates for racial and ethnic groups from other reports based on the 2000 census. For a discussion of this issue, see Demographics, the Technical Notes and the Glossary in the *Health of Boston 2001,* recently published.

SUMMARY OF CAUTIONS

1. Population figures used in the report to calculate rates come from the 1990 Modified Age-Race-Sex File for Boston Census Tracts, drawn from the 1990 census.

2. Racial and ethnic designations come from the 1990 census and are used for the calculation of rates.

3. The age-adjusted mortality rates presented in this report cannot be compared to any age-adjusted mortality rates presented the *Health of Boston 2001*, recently published by the Boston Public Health Commission.

Young Men in Boston 2001:
A Health Profile

HIGHLIGHTS

This section is designed to call attention to some of the particular points and overall trends from the report's data.

Sexually Transmitted Disease

- Despite being preventable diseases, STDs claim disproportionate, high incidence rates among young men in Boston.
- Young men ages 15-24 have the highest rates for new cases of STDs among any male age group.
- Despite making up only about 20% of the total male age population, young men ages 15-24 account for about 40% of new STD cases among all male age groups combined. And despite making up about 22% of the total male age population, men ages 25-34 account for about 35% of new STD cases among all males combined. The high incidence rates of STD infections tend to cluster in young men of Black and Hispanic race/ethnicity groups.

Leading Causes of Hospitalization

- Young men in Boston are hospitalized for a variety of causes. In descending order, Injury, Psychoses and Substance Abuse are the three leading causes of hospitalization for males ages 15-24.
- Substance Abuse, Psychoses, and HIV/AIDS are the three leading causes of hospitalization for males ages 25-34.

Violent Injury

- Even though violent injuries are preventable, young men in Boston disproportionately suffer from violent injuries. In 1998, about 70% of the men treated for violent gunshot and stabbing injuries in Boston hospital emergency departments were under age 30.
- Males ages 15-34 who live in South Dorchester, North Dorchester and Roxbury make up over 55% of all the violent gunshot and stabbing injuries registered at hospital emergency departments in Boston.

Mortality

- The three leading causes of death among Boston males ages 15-24 are preventable: suicide, motor-vehicle accidents and homicide. The rate for homicide is higher than the rates for all other leading causes of death combined.
- The leading cause of death among Boston males ages 25-34 is HIV/AIDS, followed by homicide and substance abuse.
- Black men have the highest rates in overall mortality—42% higher than White and 79% higher than Hispanic males.
- Males ages 15-24 who live in Mattapan, Roxbury and North Dorchester have the highest mortality rates among men of that age group across all Boston neighborhoods. Males ages 25-34 who live in Roxbury, South End, and Mattapan have the highest mortality rates among men of that age group across all Boston neighborhoods.

Homicide Mortality

- Black males at all ages have a higher homicide rate and injury rate than any other racial/ethnic group—15 times the rate for Whites and 3.5 times the rate for Hispanics. The homicide mortality rate for males ages 15-24 is more than double the rate for males ages 25-34. Mattapan, North Dorchester and Roxbury have the highest homicide mortality rates in the city.

HIV/AIDS Deaths

- At all ages Black males have the highest death rate from HIV/AIDS of all racial/ethnic groups. For males ages 15-34, the South End has the highest rate of deaths from HIV/AIDS. The second and third highest rates of HIV/AIDS deaths among Boston neighborhoods for males ages 15-34 are in Roxbury and Mattapan.

Suicide Mortality

- Hispanic and White young men have the highest rates in suicide among ethnic/racial groupings for males of all ages.
- For males ages 15-34, South Boston holds the highest suicide mortality rate in Boston, followed by West Roxbury and East Boston.

Substance Abuse Mortality

- Though the rates of mortality among Boston males from substance abuse have declined, a few neighborhoods still have high rates of mortality due to substance abuse—Charlestown, South Boston and East Boston.
- White and Hispanic males overall have the highest age-adjusted morality rates for substance abuse of all ethnic and racial groups.

Heart Disease Mortality

- Heart disease mortality rates are highest among Black and White males, and lowest among Hispanics and Asians.

Access To Health Care

- For men between the ages of 18-24 who are employed, about 1 in 5 do not have employer health care coverage. And for employed men ages 25-34, about 1 in 4 do not have employer health care coverage.
- Black and Hispanic men between ages 18-34 are more likely to lack health insurance than other similarly aged men in Boston.

Smoking

- For men between the ages of 18-24, about 1 in 5 are current smokers, and for men ages 25-34, slightly less than 1 in 5 are current smokers.

INTRODUCTION

The health of men in Boston is an issue of increasing concern. Men of all ages have higher rates of death from preventable diseases than women. In addition, men are less likely to seek health care services. While some of the health differences between men and women are due to biological differences, increasingly experts are coming to understand the way that ideas about the meaning of masculinity affect the way that men look their health.

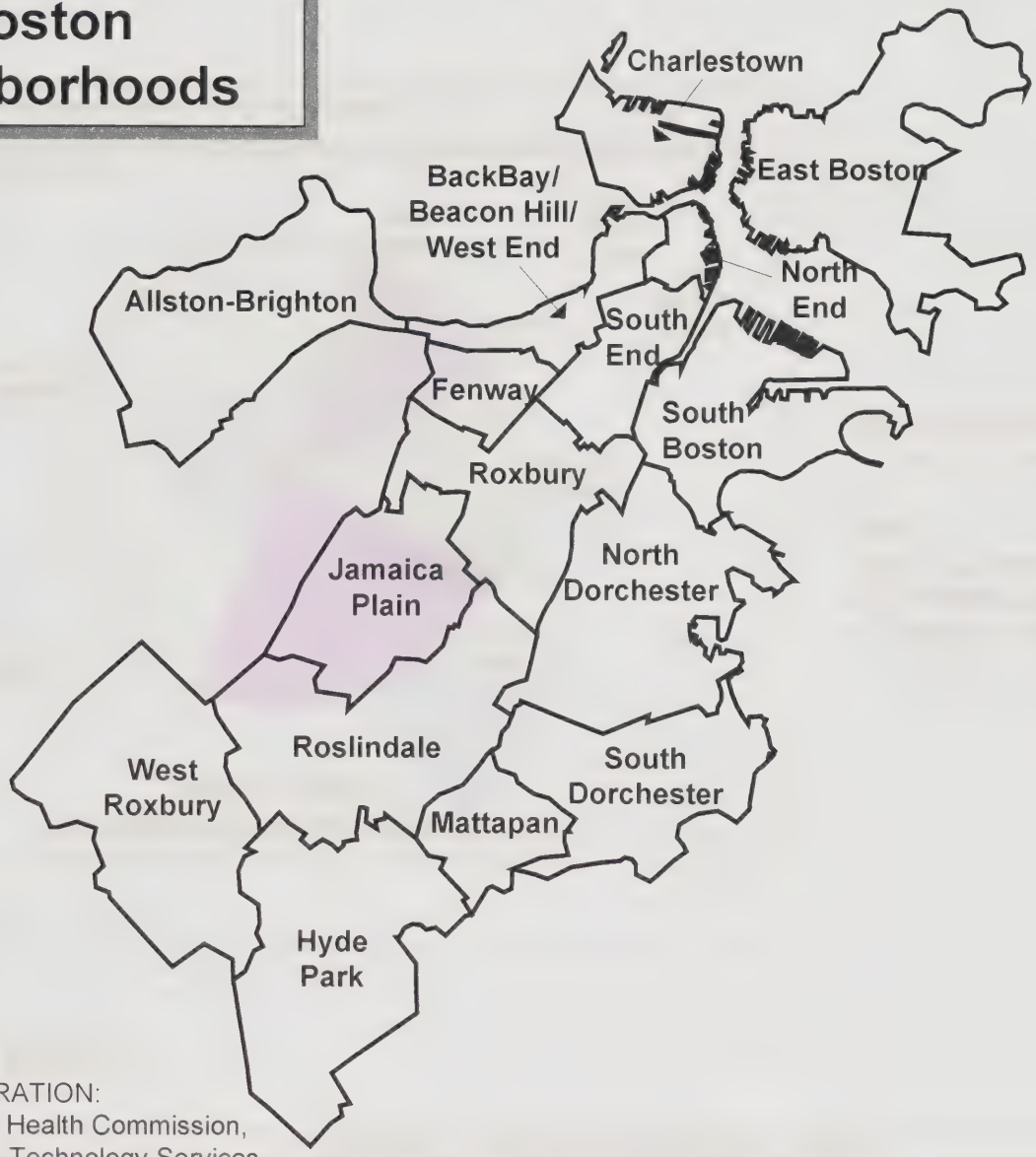
This report focuses on young men between the ages of 15 and 34 because they are often disproportionately affected by preventable diseases, and, because of lack of insurance, have less access to preventive medical care. The youngest of these men (ages 15-24) have higher rates of preventable diseases like sexually transmitted diseases and violence. Among those ages 25-34, substance abuse, HIV/AIDS and other chronic diseases begin to appear. While men across the whole age span have higher rates of mortality than women, younger men present unrealized opportunities for disease prevention and health promotion.

Some important racial differences in health status exist among young men. It is important to stress the fact that these differences are not based on biological differences but rather relate to social conditions that are associated with race. These conditions go far beyond individual behaviors to include poverty, racial and ethnic discrimination, disproportionate incarceration, and lack of access to effective primary health care. For this reason, readers will note that young men who live in poorer neighborhoods or neighborhoods with larger proportions of people of color often have health status indicators that are worse than the city as a whole.

The data presented in this report should be useful to public, private and community-based organizations as they prepare coordinated programmatic responses to the structural barriers fueling the problems affecting young men, particularly those who are most vulnerable.

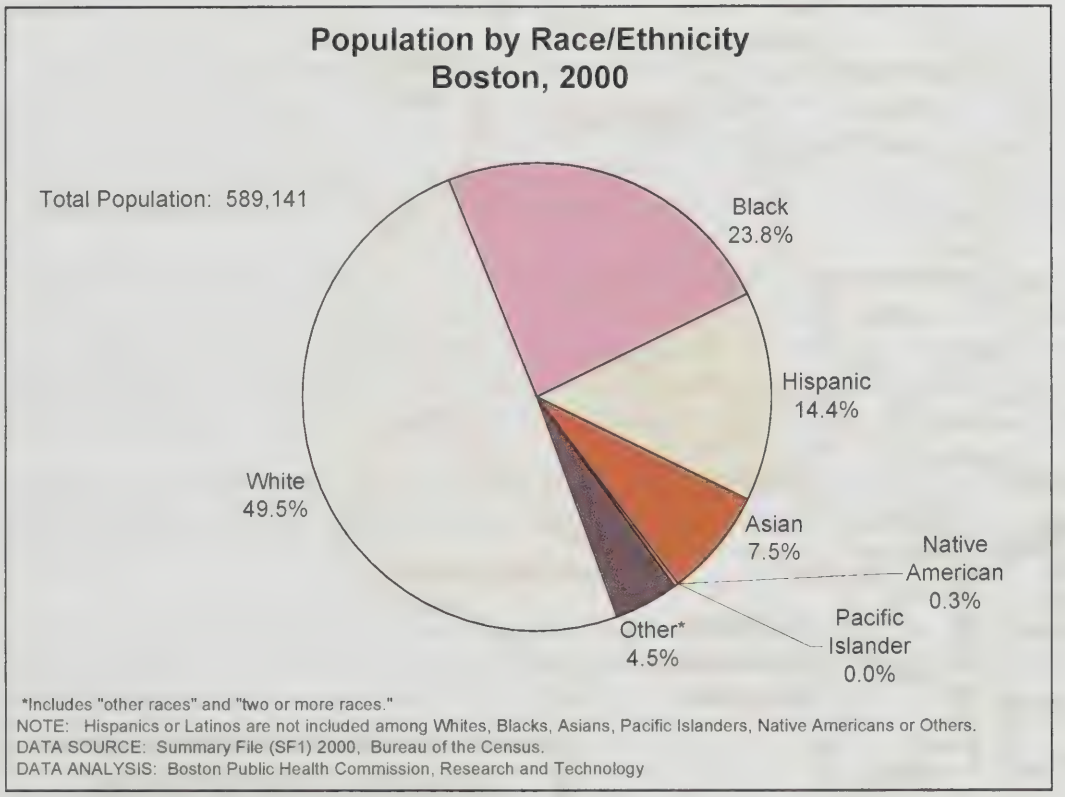
The data publications generated every year by the Commission fulfill one of the important goals of *Healthy People 2010*, to increase the proportion of the population that has access to public health information and surveillance data. Publications produced by the BPHC Research Office can be obtained by calling (617) 534-4757.

Boston Neighborhoods



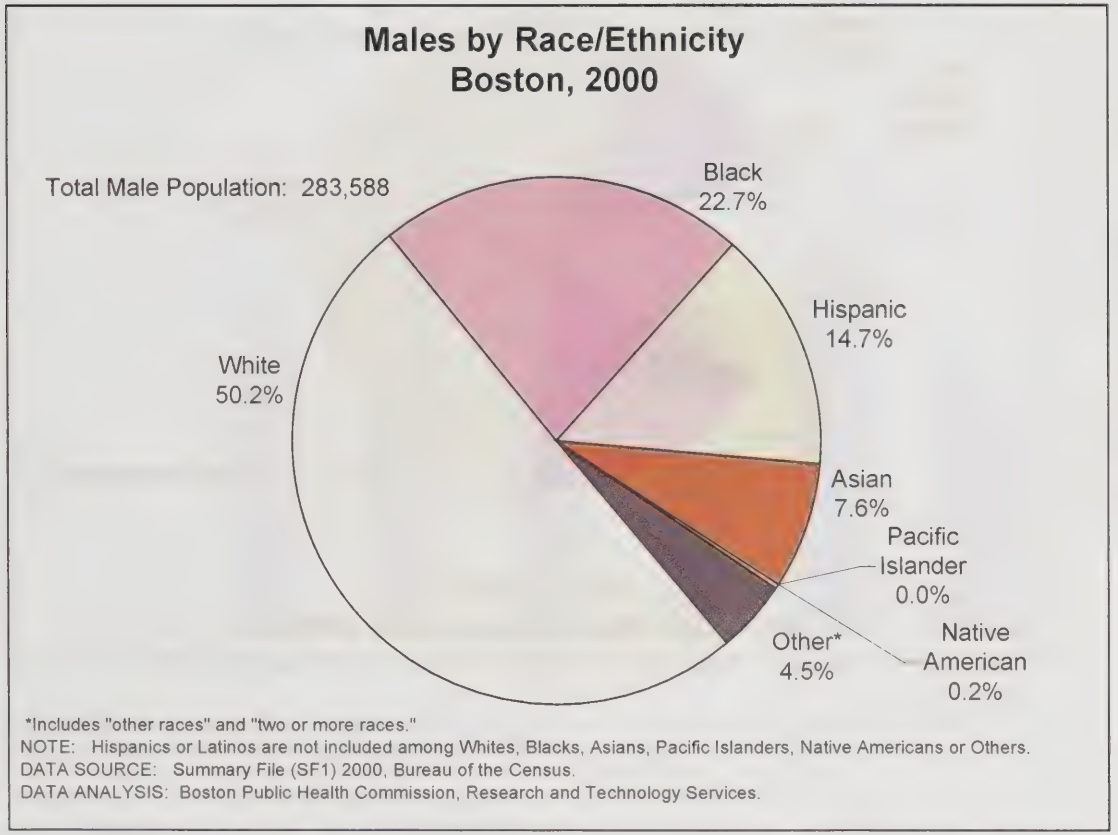
MAP PREPARATION:
Boston Public Health Commission,
Research and Technology Services.

DEMOGRAPHICS

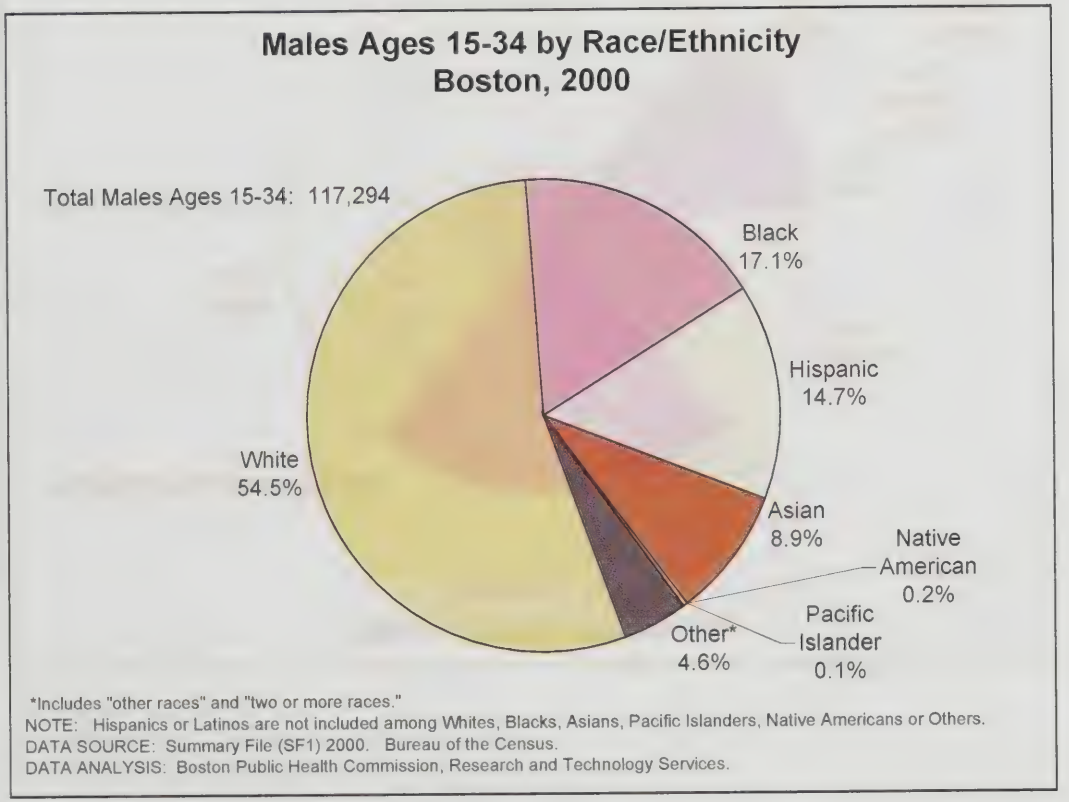


- The 2000 census indicates that almost fifty percent of the Boston population is White, 25% Black, 15% Hispanic, and 8% Asian.

- Native Americans and others make up the remaining population.



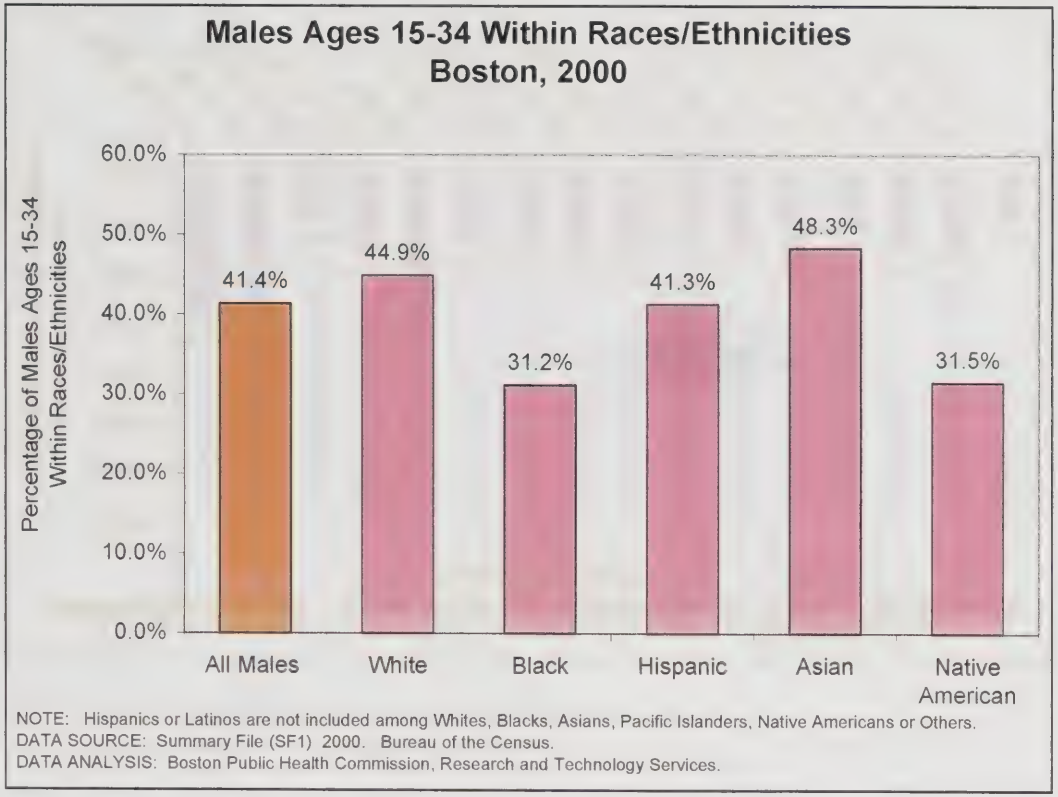
- The 2000 census indicates that almost fifty percent of the Boston population is White, 25% Black, 15% Hispanic, and 8% Asian. Native Americans and others make up the remaining population.



- Based on the 2000 census, the population of males ages 15-34 is 117,294. This is 41.4% of the total Boston male population.

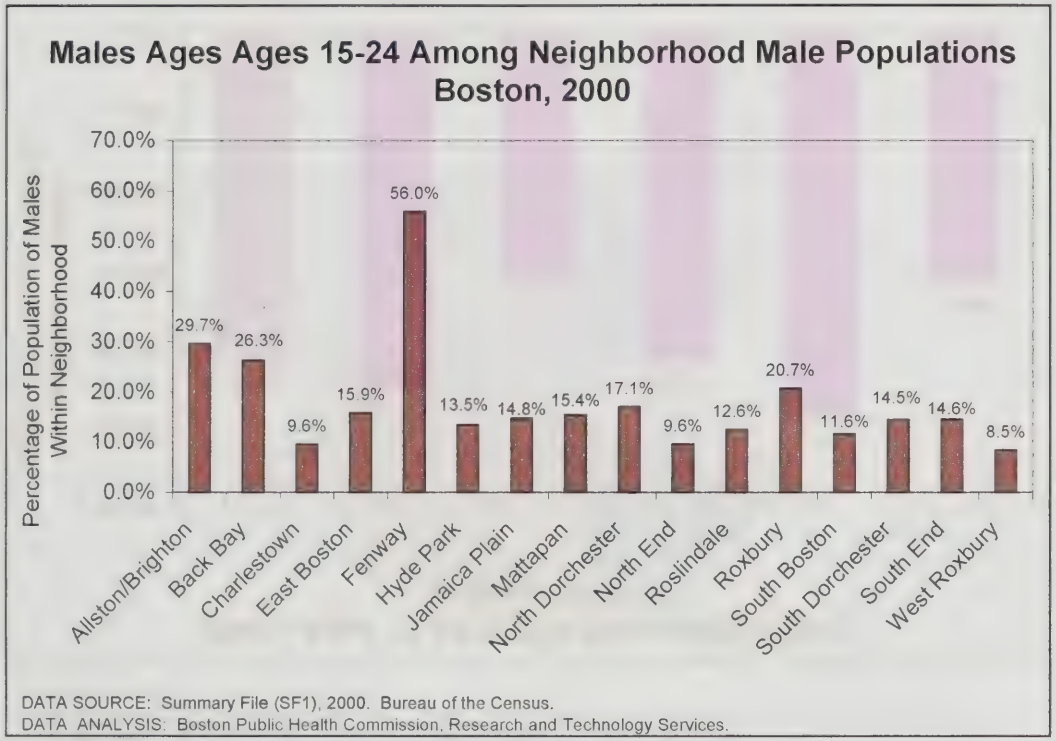
- Among Boston males ages 15-34, Whites represent almost 55%, Blacks 17%, Hispanics, 15% and Asians almost 9%.

- Native Americans and Pacific Islanders each represent less than 1% of the population.



- According to the 2000 census, Boston males ages 15-34 are a little less than half of the Asian male population, about 45% of the White male population, and about 40% of the Hispanic male population.

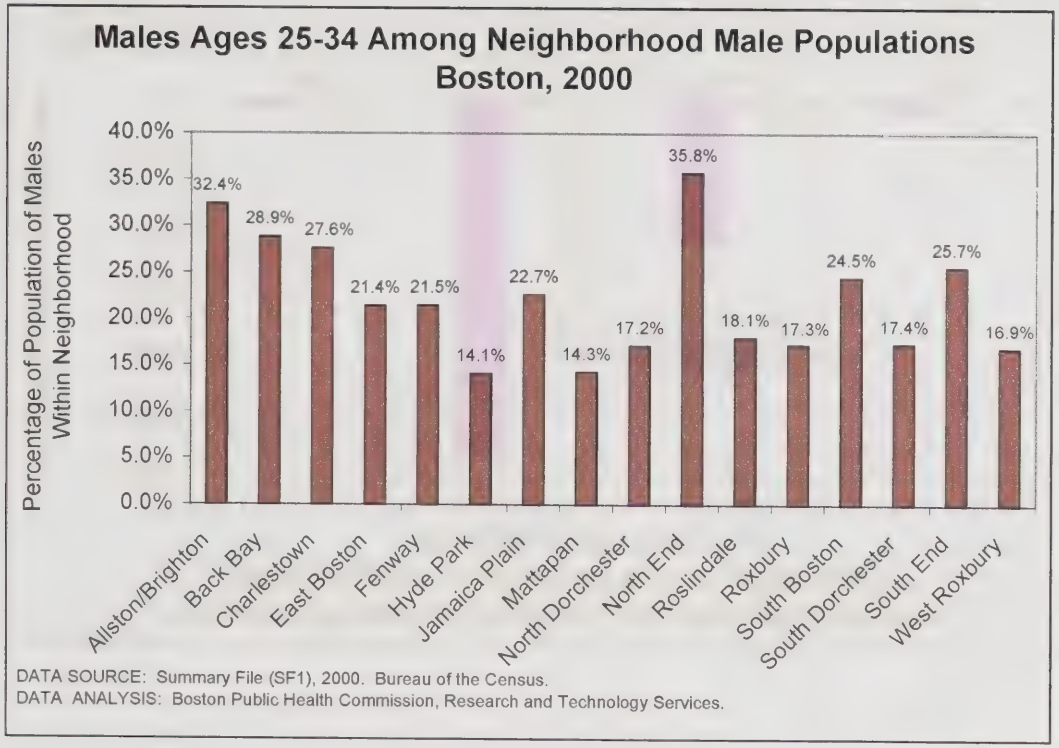
- Black and Native American males ages 15-34 each make up about 30% of the total male population in those racial and ethnic groups.



- According to the 2000 census, there are 55,249 males ages 15-24 in Boston, almost 20% of the Boston male population.

- Within Boston neighborhoods, the highest percentage of males ages 15-24 is in the Fenway, followed by males ages 15-24 in Allston/Brighton, the Back Bay, and Roxbury. The large numbers of college students that live in these neighborhoods, especially the Fenway, are partially responsible for the percentage of young males in the 15-24 age group.

- Neighborhoods with the lowest percentages of males ages 15-24, less than 10%, are Charlestown, the North End, and West Roxbury.



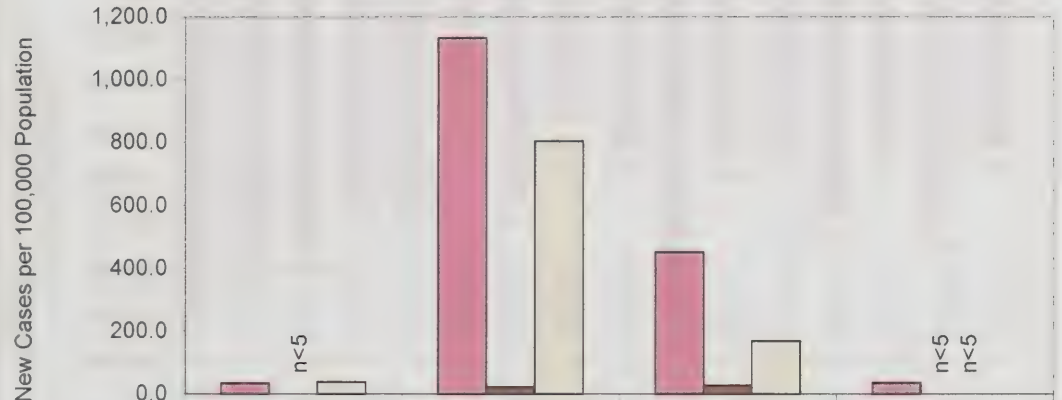
- As indicated by the 2000 census, the total population among Boston men ages 25-34 is 62,045, about 22% of the total male population.

- The North End and Allston/Brighton have the highest percentages of men ages 25-34, about one third of all males in those neighborhoods. Back Bay, Charlestown, the South End, and South Boston follow them.

- Neighborhoods with the lowest percentages of men ages 25-34 are Hyde Park and Mattapan.

SEXUALLY TRANSMITTED DISEASES

Incidence Rates of Sexually Transmitted Diseases Among Males Ages 15-24 by Race/Ethnicity Boston, 1995-1999



	White	Black	Hispanic	Asian
Chlamydia	34.7	1,133.6	450.9	36.1
Syphilis	n<5	22.7	27.2	n<5
Gonorrhea	37.6	803.9	168.4	n<5

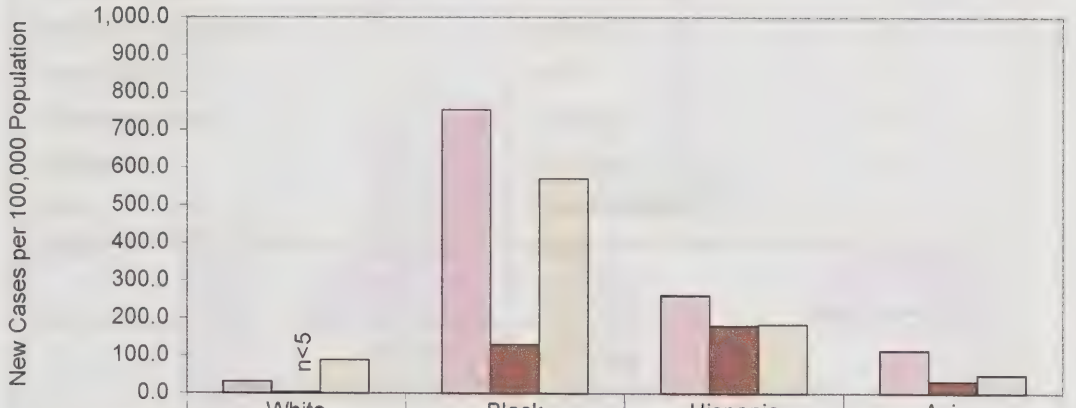
DATA SOURCE: Selected STDs for Boston Report, STD Division, Massachusetts Department of Public Health; MARS file for Boston census tracts, US census.
DATA ANALYSIS: Rates calculated by the Boston Public Health Commission, Research and Technology Services.

- Young males ages 15-24 have the highest rates for new cases of sexually transmitted diseases (STDs) of any age groups for males. During 1995-1999, there were 2,166 new cases of STDs (chlamydia, syphilis, gonorrhea) among Boston males ages 15-24, more than half of all new cases among young males ages 15-34 and 38.2% of new cases among all males.

- Rates of new cases for Black and Hispanic males ages 15-24 were higher for each STD shown than they were for White and Asian males. Blacks had the highest rates for chlamydia and for gonorrhea. The rate for syphilis was higher for Hispanics than for Blacks.

- The chlamydia rate for Blacks was 34 times higher than the rates for Whites and Asians and 2.5 times the rate for Hispanics. The gonorrhea rate for Blacks was 21 times higher than the rate for Whites and 5 times higher than the rate for Hispanics.

Incidence Rates of Sexually Transmitted Diseases Among Males Ages 25-34 by Race/Ethnicity Boston, 1995-1999



	White	Black	Hispanic	Asian
Chlamydia	30.4	753.6	259.9	113.6
Syphilis	3.3	130.0	180.6	32.4
Gonorrhea	88.0	571.0	183.3	48.7

DATA SOURCE: Selected STDs for Boston Report, STD Division, Massachusetts Department of Public Health; MARS file for Boston census tracts, US census.
DATA ANALYSIS: Rates calculated by the Boston Public Health Commission, Research and Technology Services.

- From 1995 through 1999, there were 1,991 new cases of sexually transmitted diseases (chlamydia, syphilis, gonorrhea) among Boston males ages 25-34. They accounted for almost half of all new cases among young males ages 15-34 and 35.2% of new cases among all males.

- Rates of new cases for Black and Hispanic men ages 25-34 were higher for each sexually transmitted disease shown than they were for White and Asian males. Blacks had the highest rates for chlamydia and for gonorrhea. The rate for syphilis was higher for Hispanics than for Blacks.

- The chlamydia rate for Blacks was 25 times higher than the rate for Whites, 7 times higher than the rate for Asians, and 3 times higher than the rate for Hispanics. For gonorrhea, the rate for Blacks was 6 times higher than the rate for Whites, 12 times higher than the rate for Asians, and 3 times higher than the rate for Hispanics.

LEADING CAUSES OF HOSPITALIZATION

Leading Causes of Hospitalization Average Annual Rates Among Males Ages 15-24 and 25-34 Boston, 1994-1999

Cause	Males Ages 15-24 Rate per 1,000 Population	Cause	Males Ages 25-34 Rate per 1,000 Population
Injury	3.3	Substance Abuse	7.1
Psychoses	2.4	Psychoses	4.8
Substance Abuse	1.7	HIV/AIDS	3.3
Appendectomy	1.3	Injury	3.2
Red Blood Cell Disorders	1.1	Cellulitis	1.3
Asthma/Bronchitis	0.8	Asthma/Bronchitis	1.2
Cellulitis	0.8	Appendectomy	1.2
Gastroenteritis	0.7	Gastroenteritis	1.1
Seizure & Headache	0.5	Seizure & Headache	0.9
Knee Procedures	0.4	Diabetes	0.7

DATA SOURCE: 1997-1998 Acute Hospitalization Case Mix, Massachusetts Division of Health Care and Finance Policy; 1994-1996 discharge data, Massachusetts Health Data Consortium, Inc
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

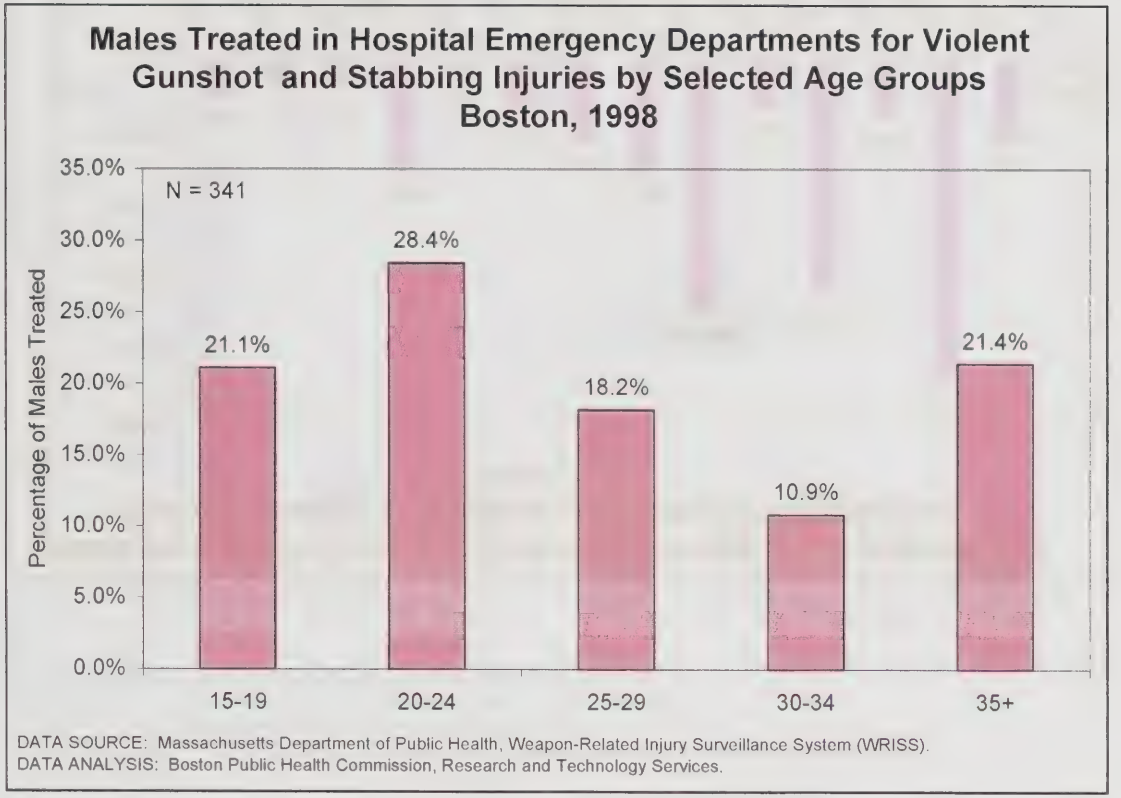
- During 1994-1999, Boston males ages 15-34 experienced 29,306 hospitalizations. Males ages 15-24 accounted for 33% and men ages 25-34, 67%.

- Leading causes of hospitalization were similar for males ages 15-24 and those ages 25-34. However, rates for ages 25-34 were higher than those for the younger age group.

- Injury was the first leading cause for males ages 15-24, psychoses the second, and substance abuse the third. Substance abuse was the first leading cause for men ages 25-34, psychoses the second, and HIV/AIDS the third, and injury the fourth.

- The substance abuse hospitalization rate was 4 times higher and the psychoses hospitalization rate 2 times higher for men ages 25-34 than for males ages 15-24.

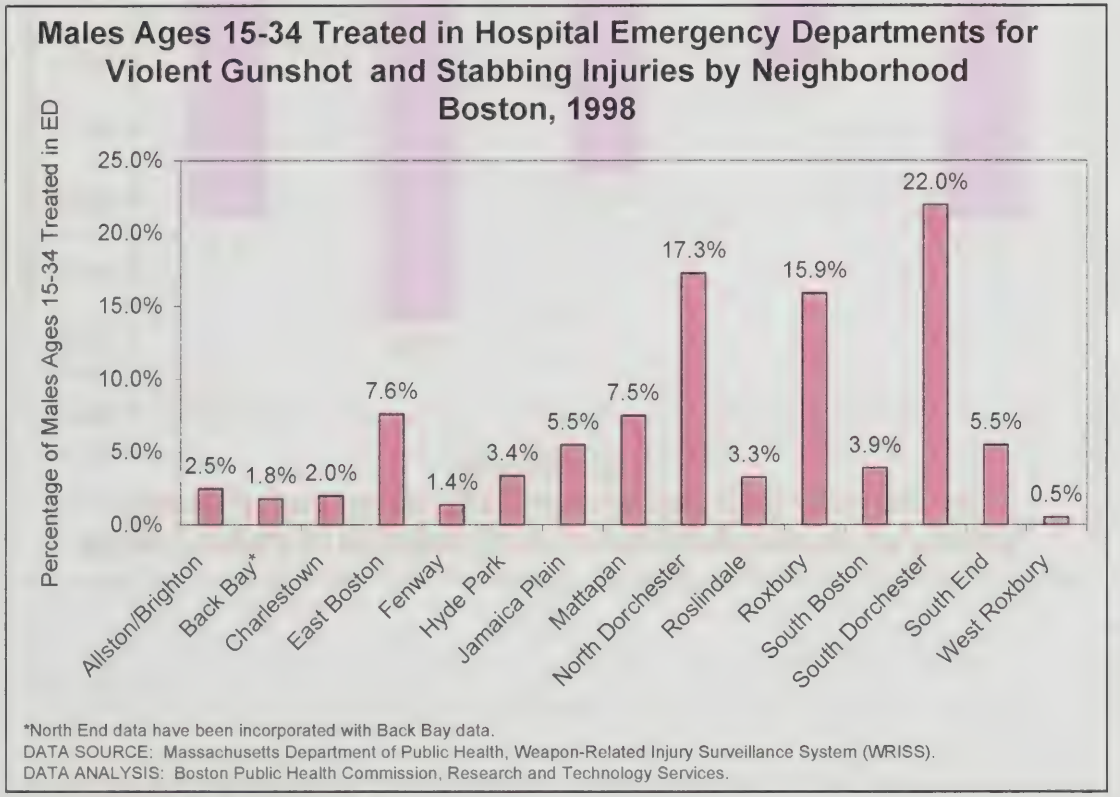
VIOLENT INJURY



- The violence-related injuries shown in the figure include intentional injuries inflicted on the victim by another person, using a firearm, non-powder gun, sharp instrument, or other/unknown gun. Violence-related injuries are distinguished from accidental injuries and from self-inflicted injuries.

- More men ages 20-24 are treated in hospital emergency departments for violent gunshot and stabbing injuries than males of other ages.

- Sixty-eight percent of the men treated for violence-related injuries in hospital emergency departments were under age 30.

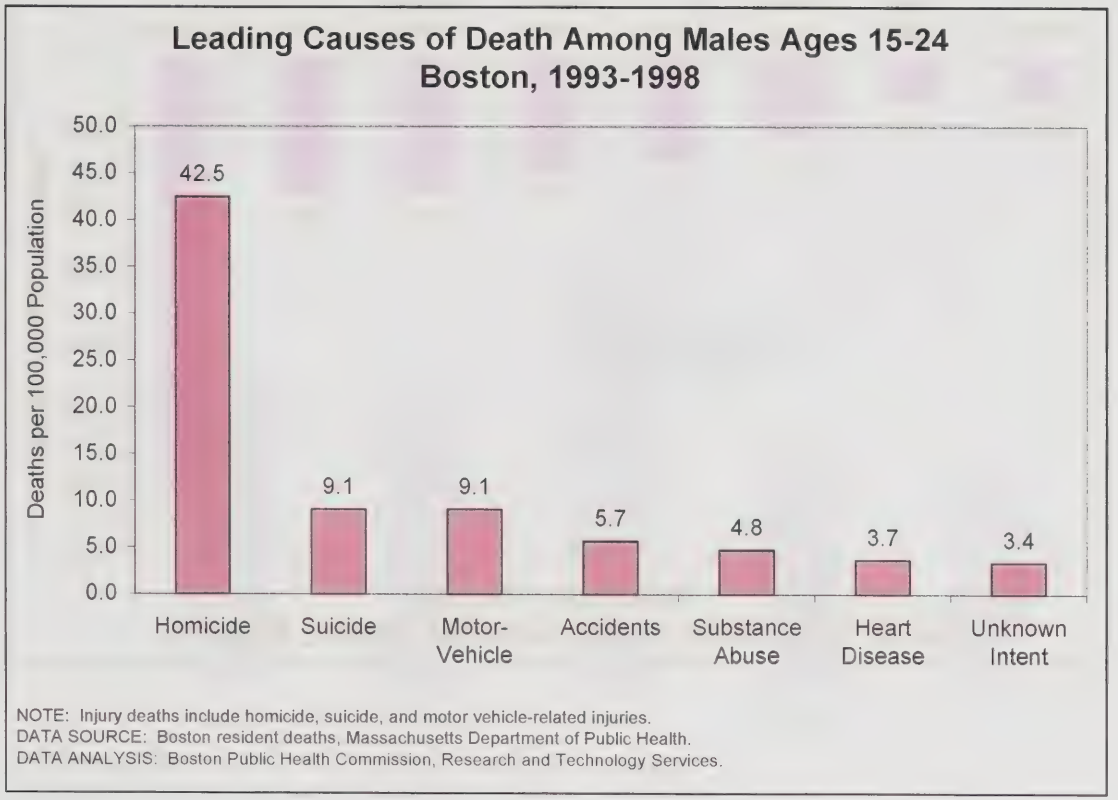


*North End data have been incorporated with Back Bay data.
DATA SOURCE: Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System (WRISS).
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

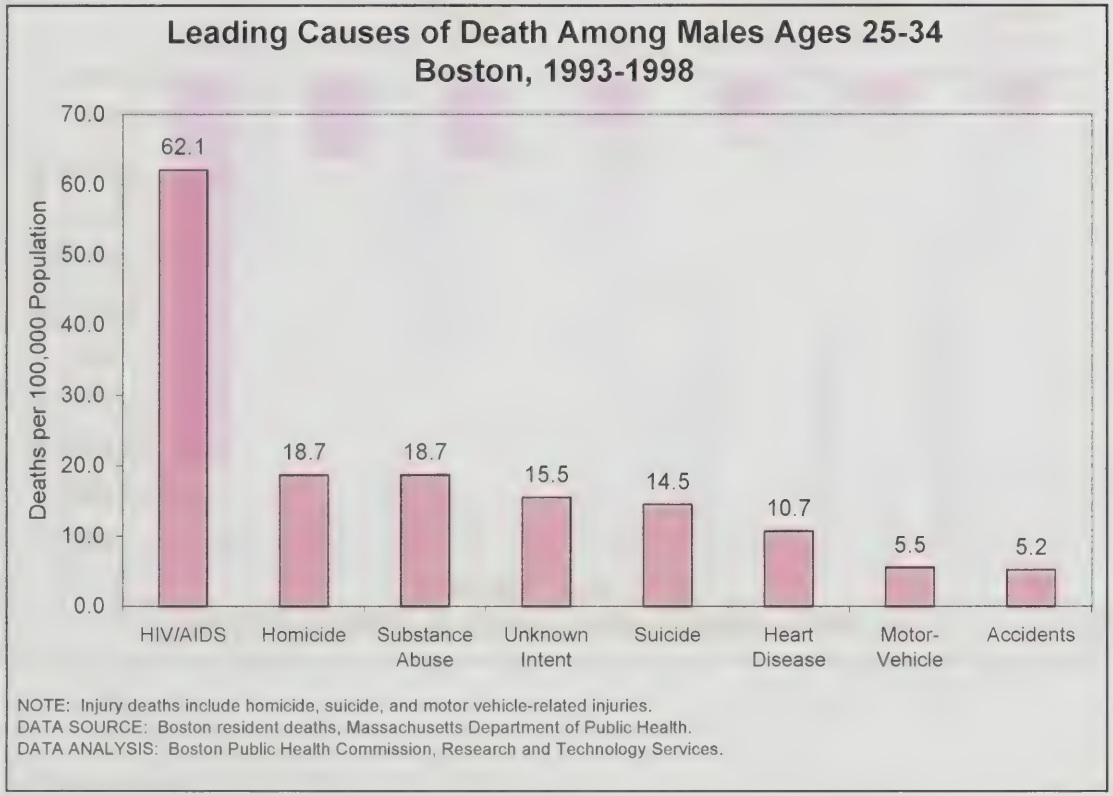
- Of males ages 15-34 treated in hospital emergency departments for violent gunshot and stabbing injuries, the greatest percentages come from South Dorchester, followed North Dorchester and Roxbury.

- Neighborhoods with the lowest percentages are West Roxbury, the Fenway, the Back Bay, and Charlestown.

MORTALITY

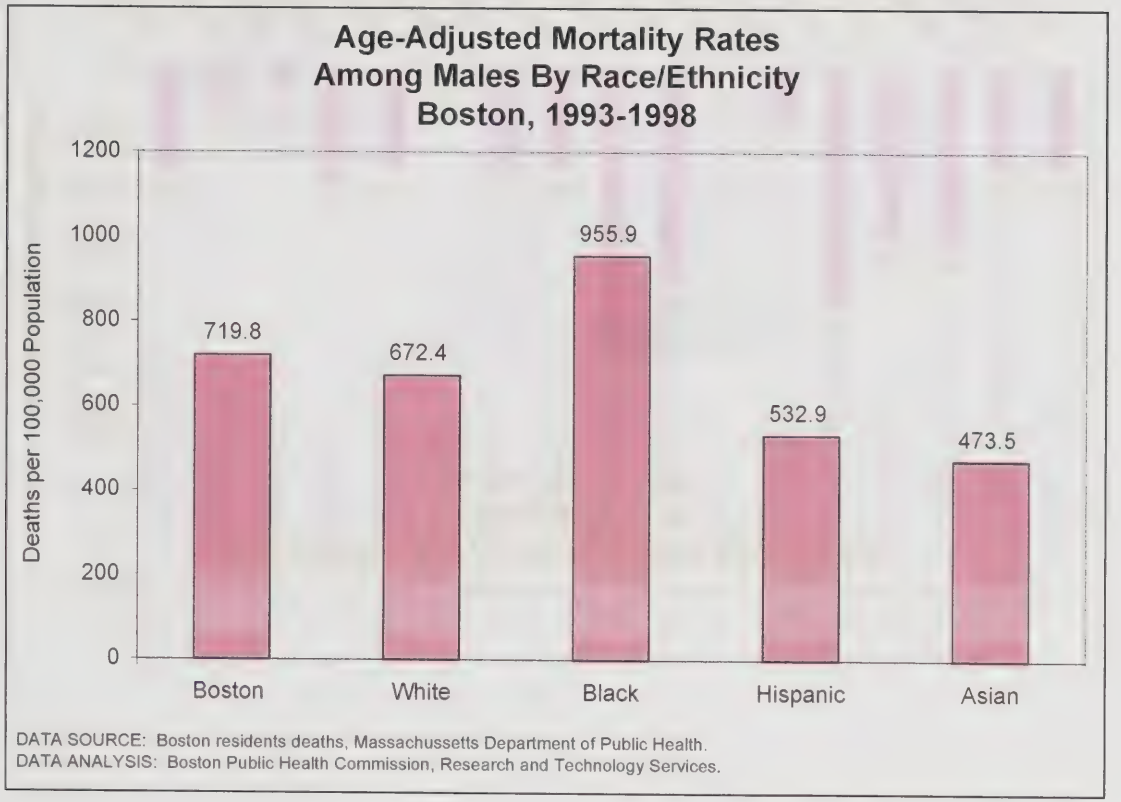


- During 1993-1998, the leading cause of death among Boston males ages 15-24 was homicide.
- The mortality rate from all injuries was 69.7 deaths per 100,000.
- The mortality rate for homicide was more than 4.7 times the rate for suicide (the second leading cause of death), and 9-12 times greater than other leading causes such as substance abuse and heart disease.
- Motor vehicle-related injuries, and accidents were also among the leading causes of death for young men in Boston.



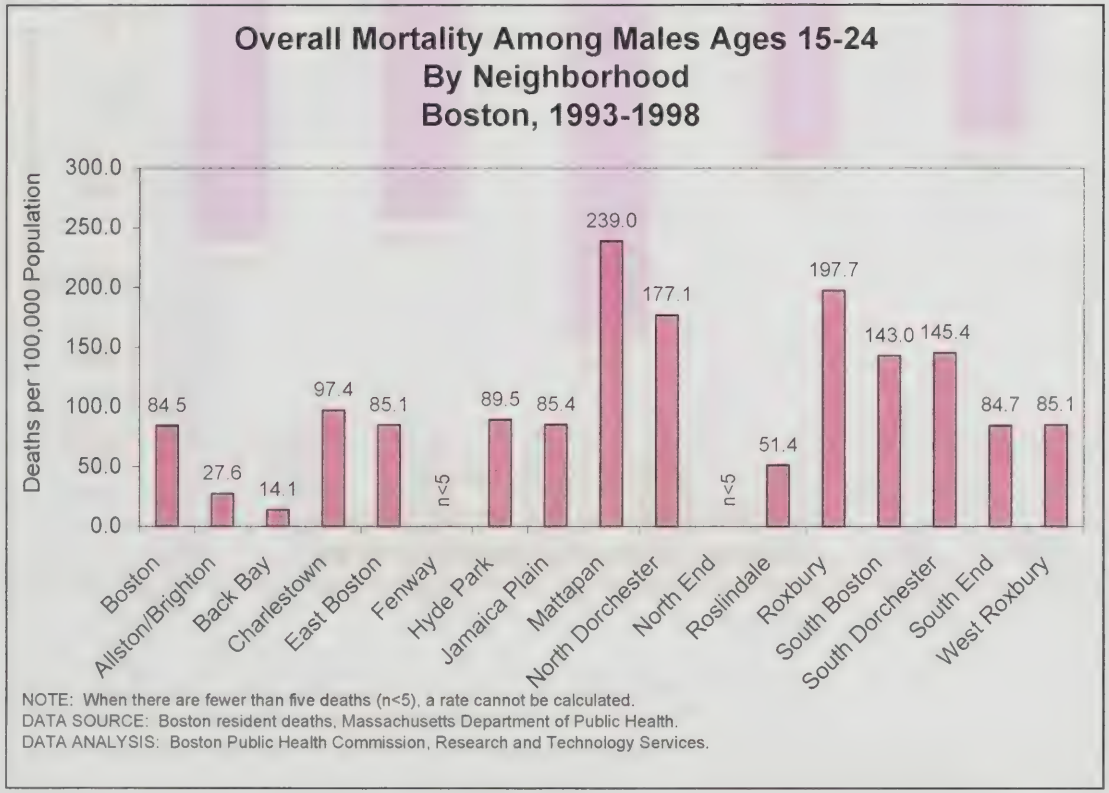
- During 1993-1998, HIV/AIDS was the leading cause of death among Boston men ages 25-34. The HIV/AIDS mortality rate was 3 times greater than homicide and substance abuse.

- Suicide, heart disease, and motor-vehicle related and other injuries were also among the leading causes of death.



- During 1993-1998, overall mortality rates based on all causes of death varied for Boston males by race/ethnicity. The rate for Black males was higher than for other races/ethnicities. The mortality rate was 42.2% higher than the rate for White males, 79.4% higher than the rate for Hispanic males, and twice the rate for Asian males.

- In this age group, Asian males had the lowest overall mortality rate among Boston races/ethnicities.

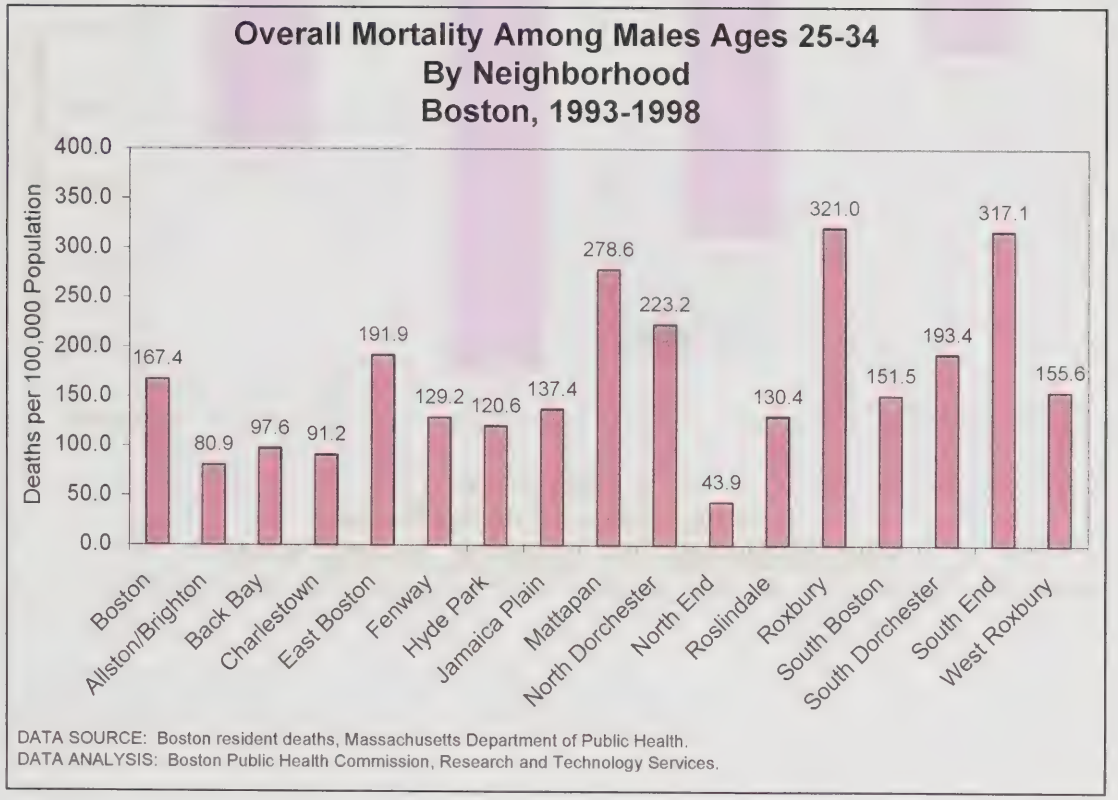


- Overall mortality rates during 1993-1998 for Boston males ages 15-24 varied by neighborhood.

- Although rates for several neighborhoods were above the Boston rate, rates for Mattapan, Roxbury, and North Dorchester were the first, second, and third highest rates among Boston's 16 neighborhoods.

- The rate for Mattapan was nearly three times the rate for Boston, the Roxbury rate more than double, and the North Dorchester rate double the rate for Boston.

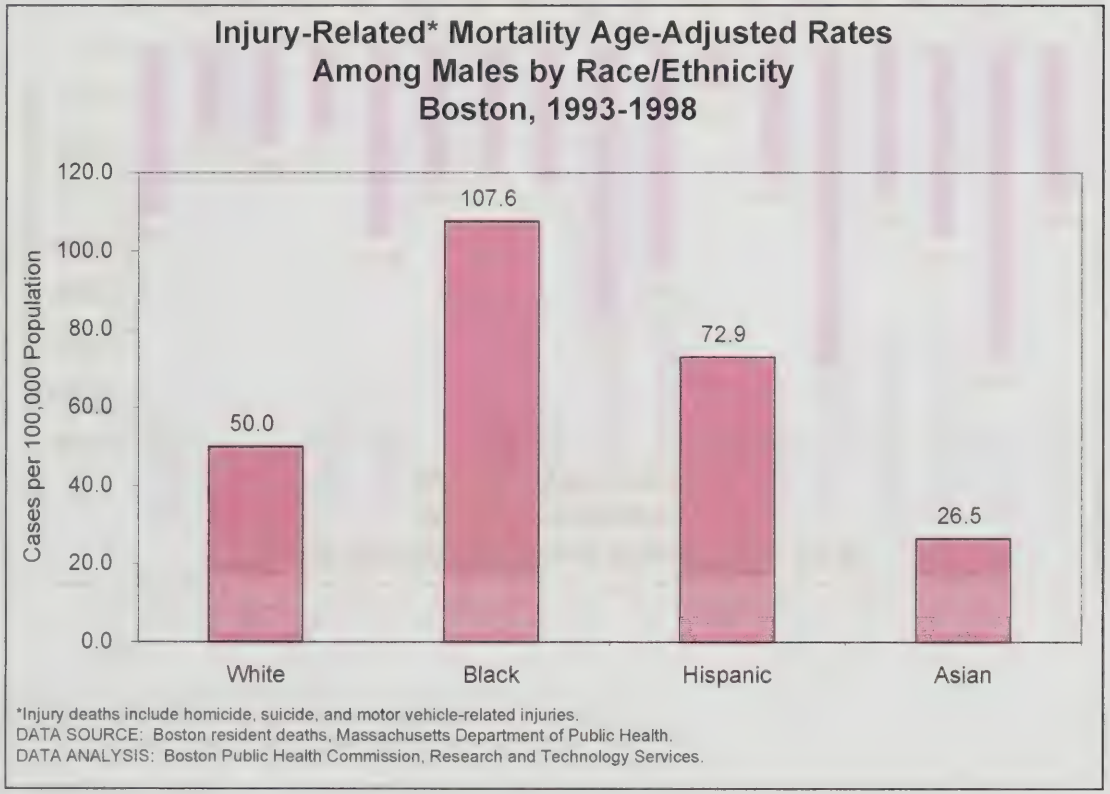
- Overall mortality rates for Allston/Brighton, Back Bay, and Roslindale were below the Boston rate. Two neighborhoods, the Fenway and the North End, each had fewer than 5 deaths among males ages 15-24 during 1993-1998.



- Overall mortality rates during 1993-1998 for Boston men ages 25-34 varied by neighborhood.

- Rates for 6 neighborhoods, in particular, were higher than the rate for Boston. Those neighborhoods were East Boston (14.6% higher), South Dorchester (15.5% higher), North Dorchester (33.3% higher), Mattapan (66.4% higher), South End (89.4% higher), and Roxbury (91.8% higher).

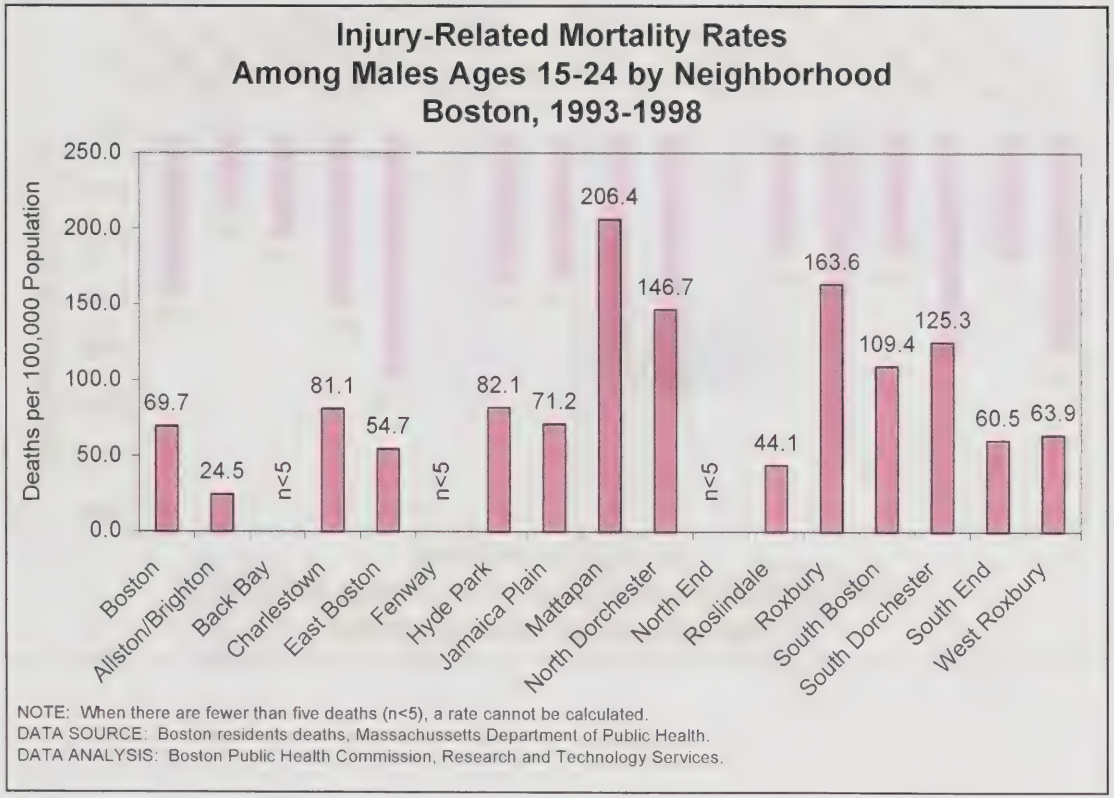
- The neighborhoods with the lowest rates, all below Boston's, were the North End, Allston/Brighton, Charlestown, and the Back Bay.



- For 1993-1998, injury-related mortality among Boston males varied by race/ethnicity. Black males experienced the highest rate, and Hispanic males the second highest. Rates for Black males were 68.1% higher, and for Hispanic males, 13.9% higher than the overall Boston rate for injury-related mortality.

- The injury-related mortality rates for White and Asian males were both below the Boston rate.

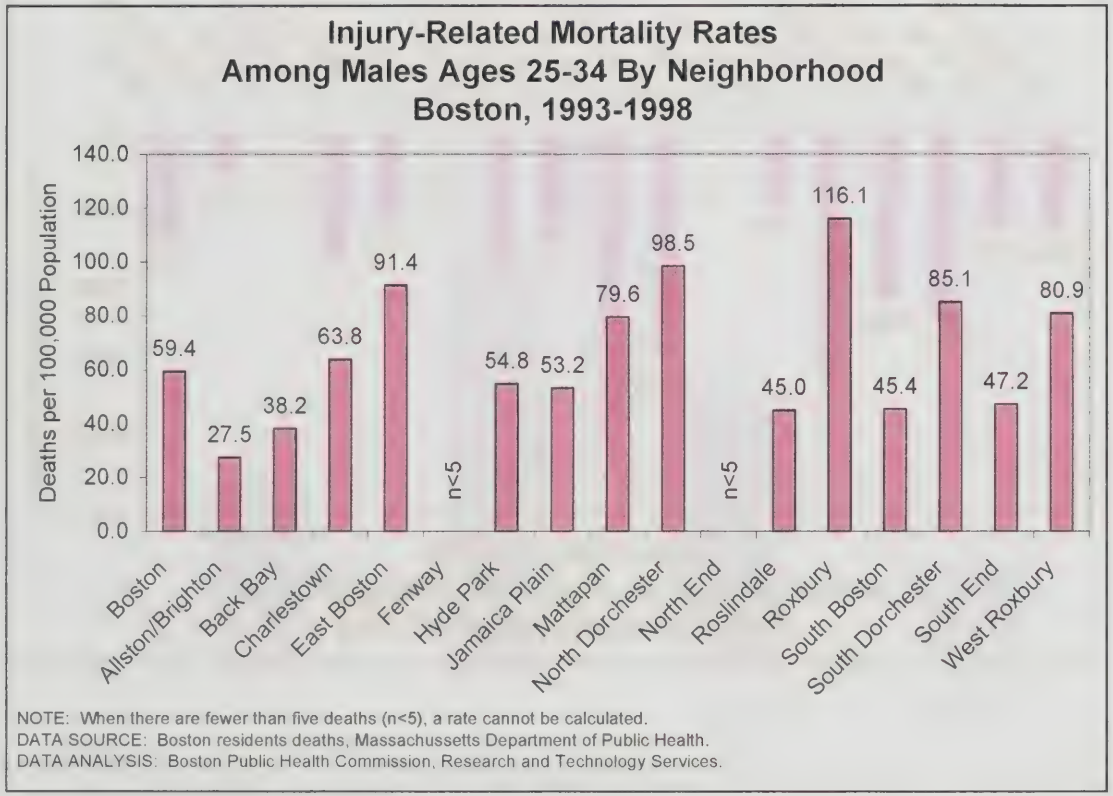
- For White males, the rate was 21.9% below and for Asian males, 58.6% below.



- Injury-related mortality rates among Boston males ages 15-24 varied by neighborhood. During 1993-1998, rates were 2-3 times higher than the Boston rate for the neighborhoods of South Boston, South Dorchester, North Dorchester, Roxbury, and Mattapan.

- The injury-related rate for Mattapan males ages 15-24, which was the highest rate of all Boston's 16 neighborhoods, was nearly three times greater than the injury-related mortality rate for Boston males ages 15-24. The rates for Roxbury and North Dorchester were at least double the rate for Boston.

- A few neighborhoods had rates that were lower than the Boston rate. Those neighborhoods included Allston/Brighton, East Boston, Roslindale, the South End, and West Roxbury. The Back Bay, the Fenway, and the North End each had fewer than 5 injury-related deaths among male residents ages 15-24 during 1993-1998.

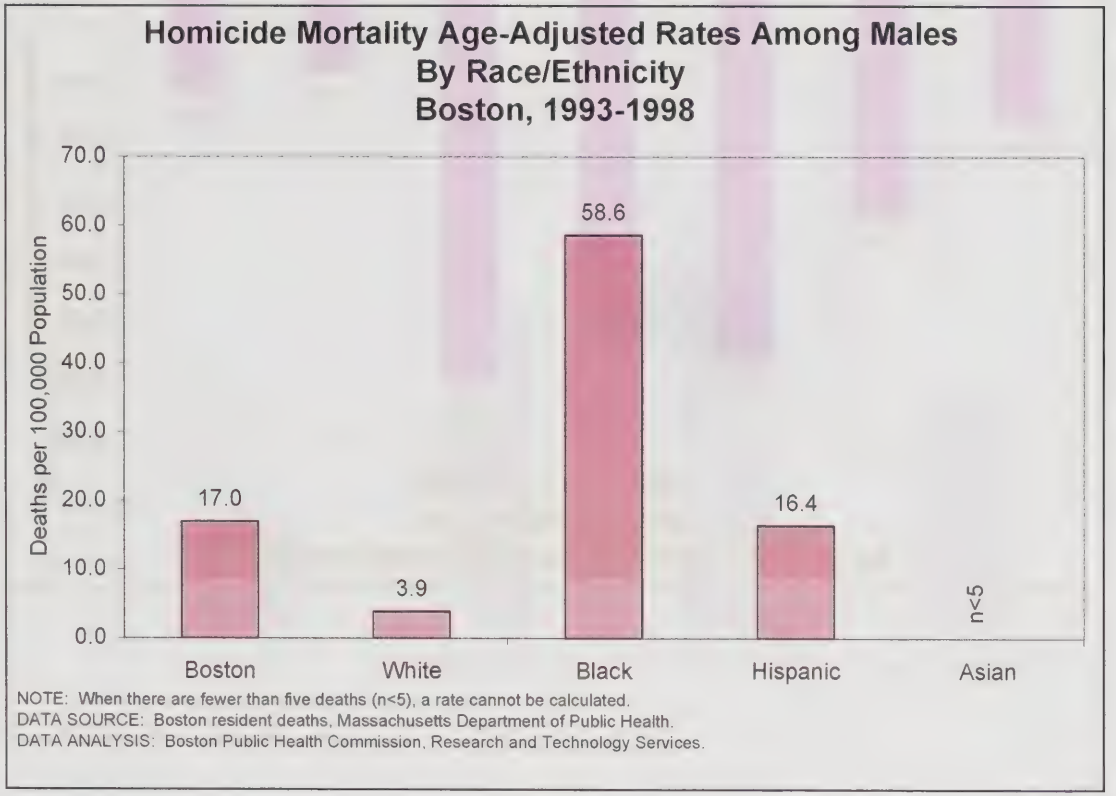


NOTE: When there are fewer than five deaths (n<5), a rate cannot be calculated.
DATA SOURCE: Boston residents deaths, Massachussetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

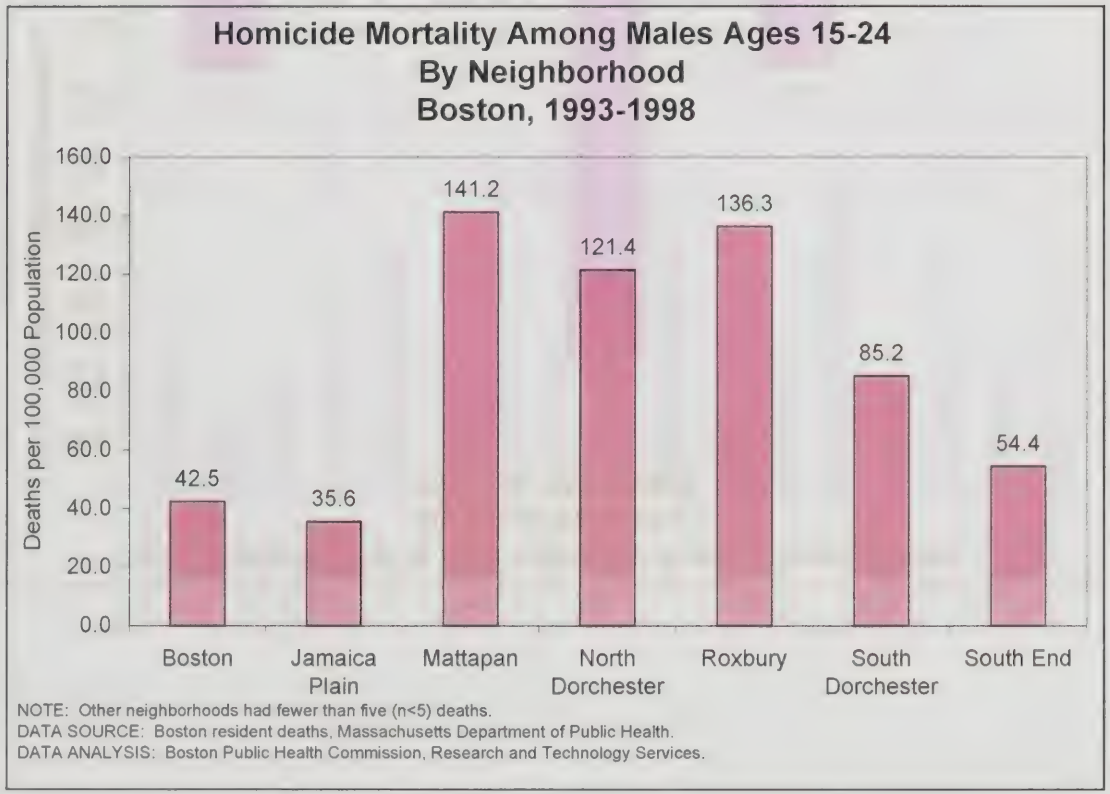
- During 1993-1998, injury-related mortality rates for Boston men ages 25-34 varied by neighborhood. Although rates for several neighborhoods were above the Boston injury-related mortality rate for men ages 25-34, those for Roxbury, North Dorchester, East Boston, and South Dorchester were higher than the Boston rate.

- The rate for Roxbury, which was the highest among Boston's neighborhoods, was almost twice as high as the injury-related rate for Boston men ages 25-34. The rates for North Dorchester, East Boston, and South Dorchester were about 1.5 times higher than the Boston rate.

- Although several neighborhoods had rates lower than the Boston rate, the rates for Allston/Brighton and Back Bay were 53.7% and 35.7% lower.

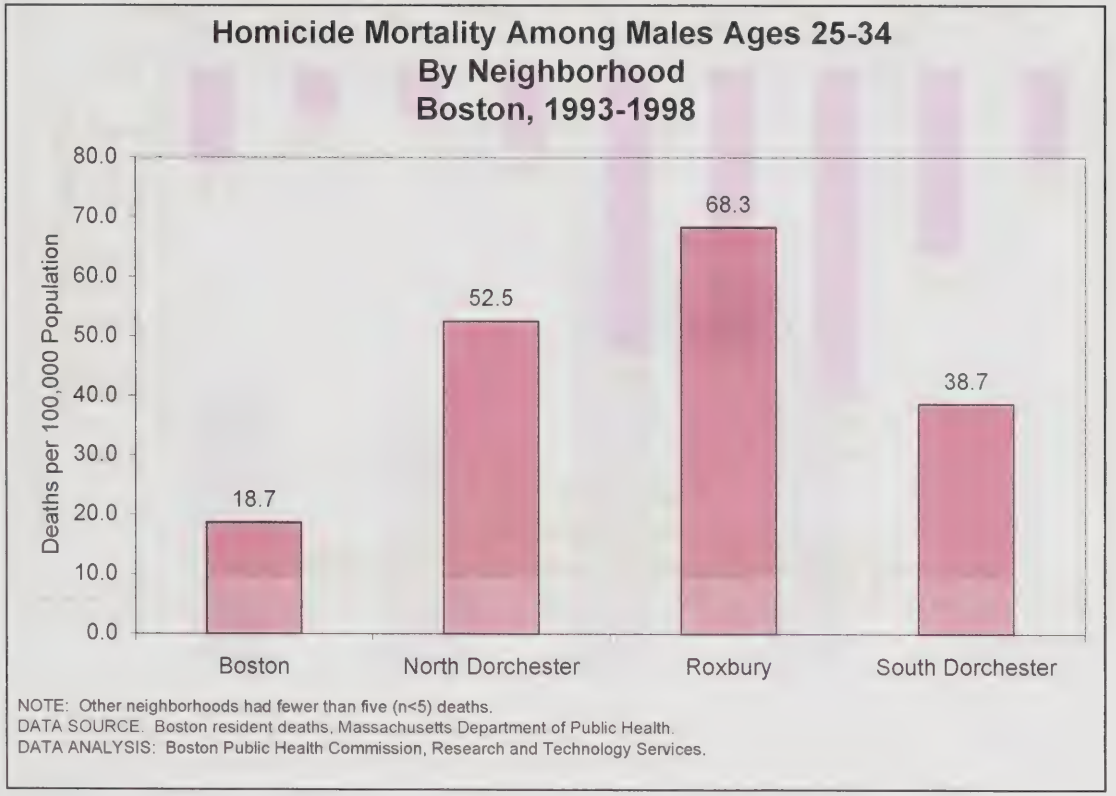


- During 1993-1998, homicide mortality rates among all Boston males were greatest for Blacks. Their rate was almost 3.5 times the overall Boston rate and the rate for Hispanics, and 15 times the rate for Whites. Among race/ethnicities, Whites had the lowest homicide mortality rate.



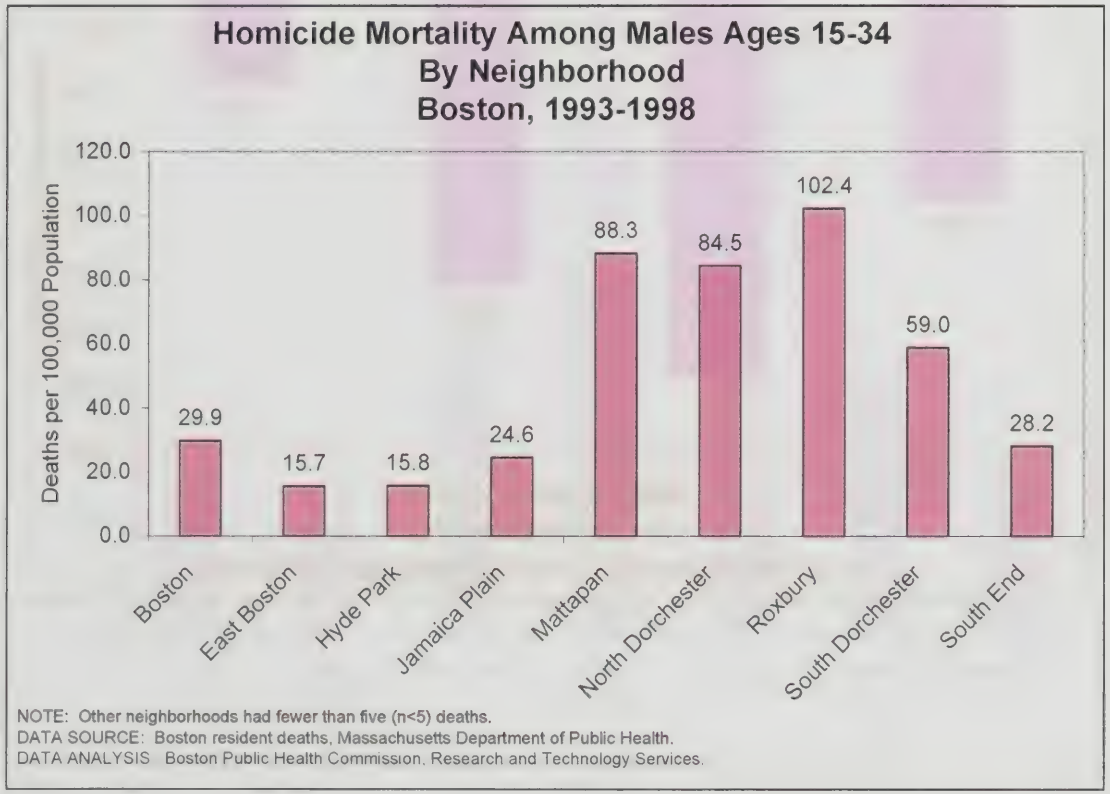
- Boston homicide mortality rates for males ages 15-24 during 1993-1998 were highest in Mattapan, Roxbury, and North Dorchester. The rates for these neighborhoods were about three times higher than the overall homicide mortality rate for Boston. The rate for South Dorchester, the fourth highest homicide mortality rate, was twice the Boston rate.

- Rates for the South End and for Jamaica Plain were the lowest homicide mortality rates among the neighborhoods for which rates could be calculated. Neighborhoods which are not shown had fewer than 5 homicides each among males ages 15-24, too few for calculation of homicide mortality rates.



- During 1993-1998, homicide mortality rates among men ages 25-34 were greatest for Roxbury, North Dorchester, and South Dorchester. The rates for all 3 neighborhoods were higher than the overall Boston rate. The rate for Roxbury was 3.6 times higher, the rate for North Dorchester, 2.8 times higher, and the rate for South Dorchester, 2.1 times higher.

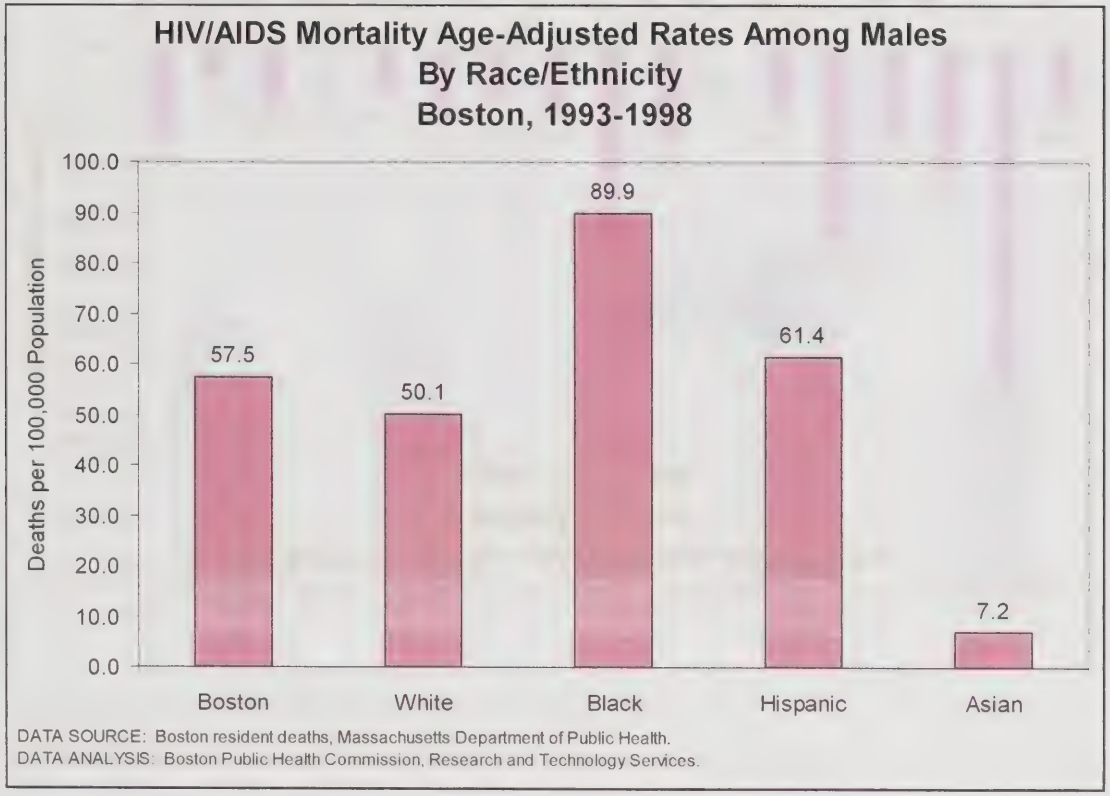
- The remaining 13 Boston neighborhoods had fewer than 5 homicides each among men ages 25-34, too few for calculation of homicide mortality rates.



- Most of the homicides among Boston males ages 15-34 that occurred during 1993-1998 were from 8 neighborhoods. Homicide mortality rates for 4 of those neighborhoods in particular—South Dorchester, North Dorchester, Mattapan, and Roxbury—exceeded the overall homicide mortality rate for Boston.

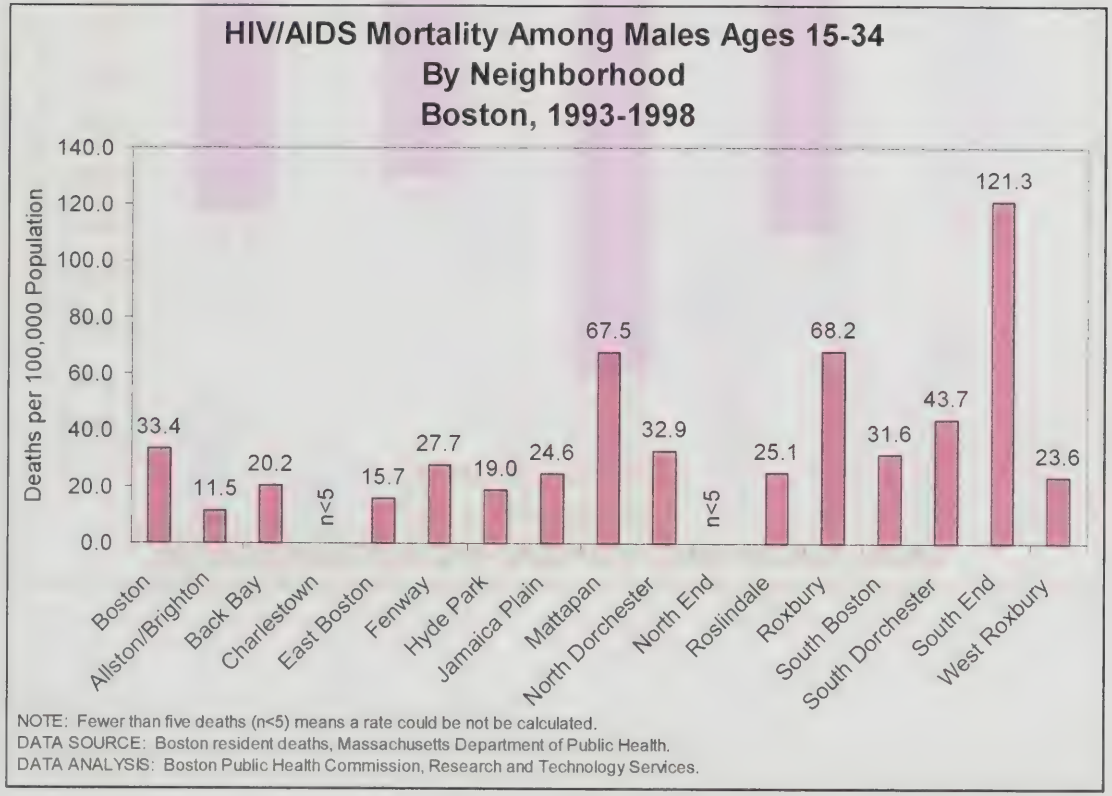
- The homicide mortality rate among males ages 15-34 in Roxbury was the highest of all Boston neighborhoods. It was almost 3.4 times the rate for Boston. The rates for Mattapan and North Dorchester were the second and third highest and nearly three times the rate for Boston.

- East Boston and Hyde Park had the lowest homicide mortality rate among the neighborhoods for which rates could be calculated. Neighborhoods which are not shown had fewer than 5 homicides each among males ages 15-34, too few for calculation of homicide mortality rates.



- Black males had the highest age-adjusted mortality rate from HIV/AIDS among all males in Boston, 56.3% higher than the rate for overall Boston, and 46.4% higher than the rate for Hispanic males.

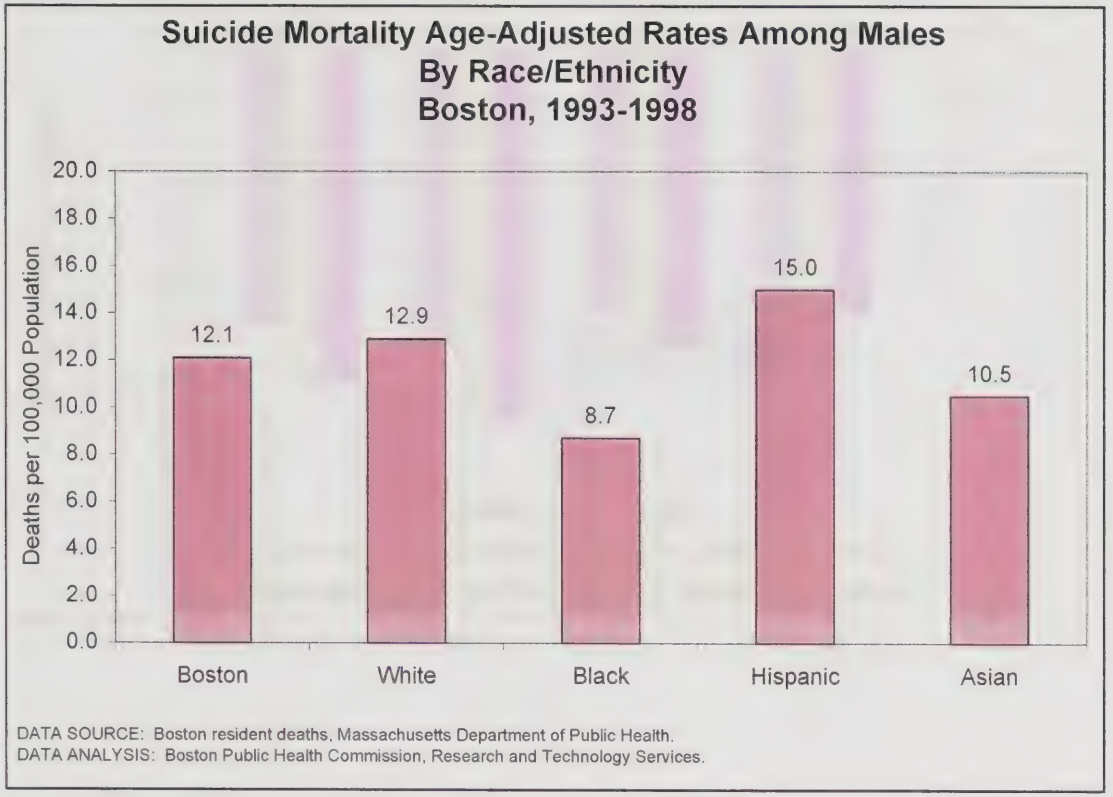
- The rate for age-adjusted mortality from HIV/AIDS among White males was 12.9% below the rate for overall Boston, and the rate for Asian males was 87.5% below the rate for overall Boston.



- The mortality rate for HIV/AIDS among males ages 15-34 living in the South End was 3.6 times higher than the overall Boston rate. It was the highest rate among Boston neighborhoods.

- The second and third highest rates were among males ages 15-34 living in Roxbury and in Mattapan. Their rates were twice as high as the overall Boston rate.

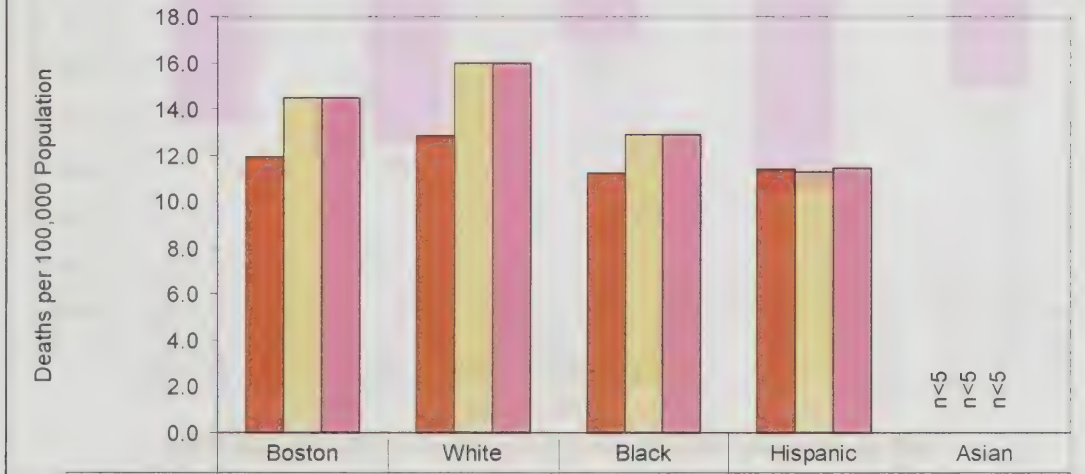
- All other neighborhoods had rates for HIV/AIDS mortality that were lower than the Boston rate. Charlestown and the North End both had too few deaths from HIV/AIDS to calculate a rate.



- The age-adjusted suicide mortality rates for Hispanics and for Whites were above the overall Boston rate, and for Blacks and Asians, below the overall Boston rate.

- Suicide rates for Hispanic males were 24.0% above the Boston rate, Asians 13.2% below the Boston rate, and Black males 28.1% below the Boston rate.

Suicide Mortality Among Males Ages 15-34 and Age Groups 15-24 and 25-34 by Race/Ethnicity Boston, 1993-1998



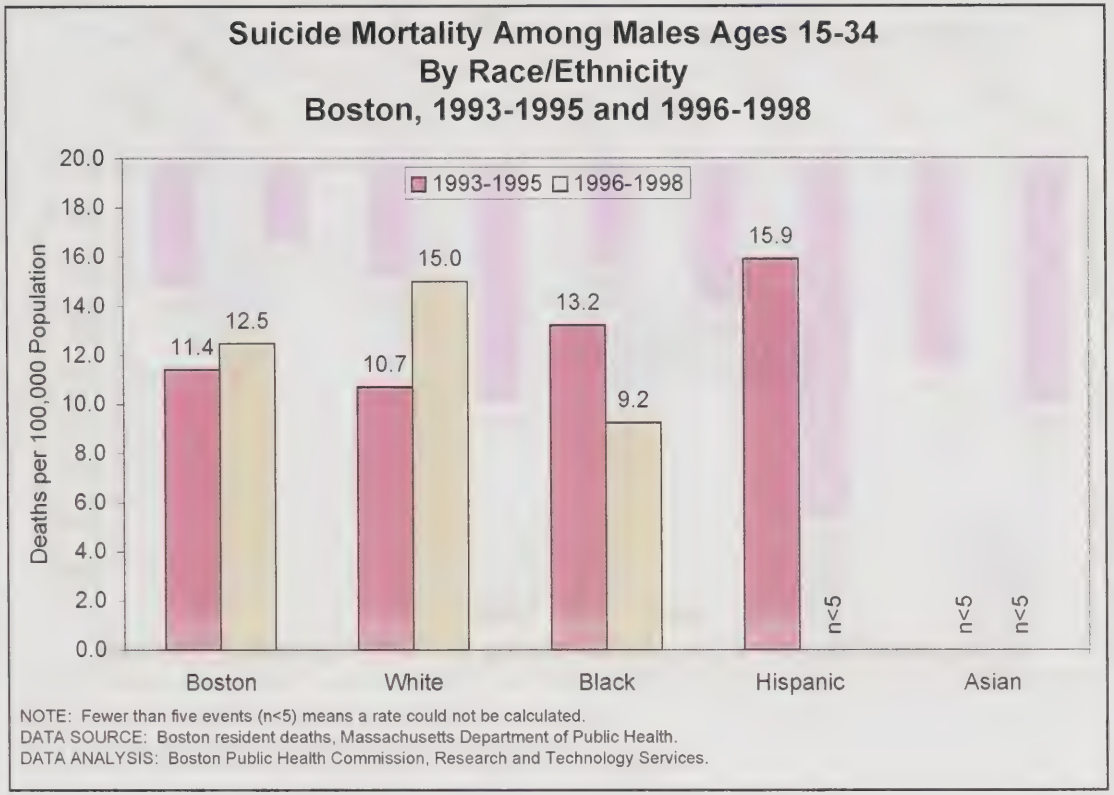
	Boston	White	Black	Hispanic	Asian
Ages 15-34	11.9	12.8	11.2	11.4	n<5
Ages 15-24	14.5	16.0	12.9	11.3	n<5
Ages 25-34	14.5	16.0	12.9	11.4	n<5

DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

- Suicide rates for Hispanic and Black males were above the Boston rate for males ages 15-24 only. They were 24.2% higher for Hispanic males and 4.4% higher for Black males in this age group. Among men ages 25-34, suicide rates for Hispanic and Black men were 21.4% and 11.0% lower than the Boston rate. For males ages 15-34, they were 4.2% and 5.9% lower.

- The suicide rate for White males was below the Boston rate for ages 15-24 but above the Boston rate for those 25-34 and 15-34. The rate was 10.3% higher than the Boston rate for White men ages 25-34 and 7.6% higher for those ages 15-34.

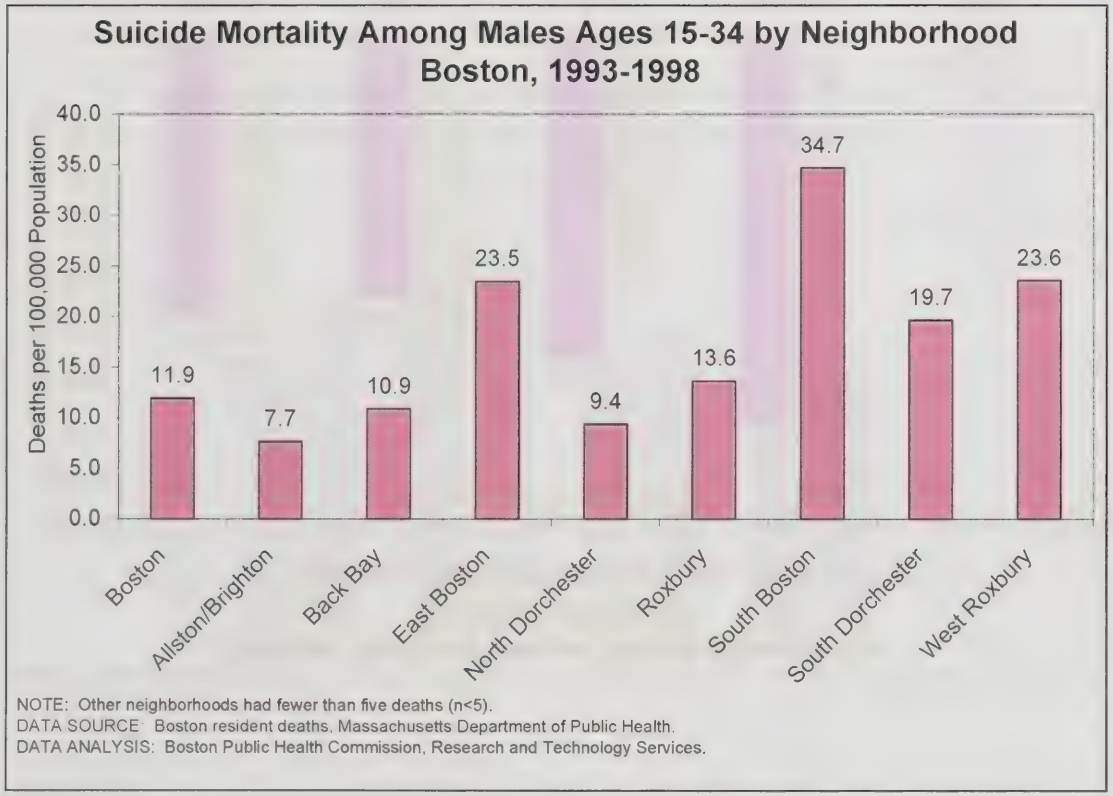
- There were too few suicides among young Asian males for calculation of suicide rates for any of the age groups presented.



- The rate of suicide mortality among males ages 15-34 increased between 1993-1995 and 1996-1998 in Boston overall (9.6%) and among White males (40.2%). It declined among Black males between the same two time periods (30.3%). It also declined for Hispanics, but there were too few suicides during the later period to calculate a rate and the extent of the decline.

- The rate among White males in 1996-1998 was 20.0% above the Boston rate, and the rate among Black males in 1996-1998 was 26.4% below the Boston rate.

- Among Asians, there were too few suicides in each of these two time periods to calculate a rate.

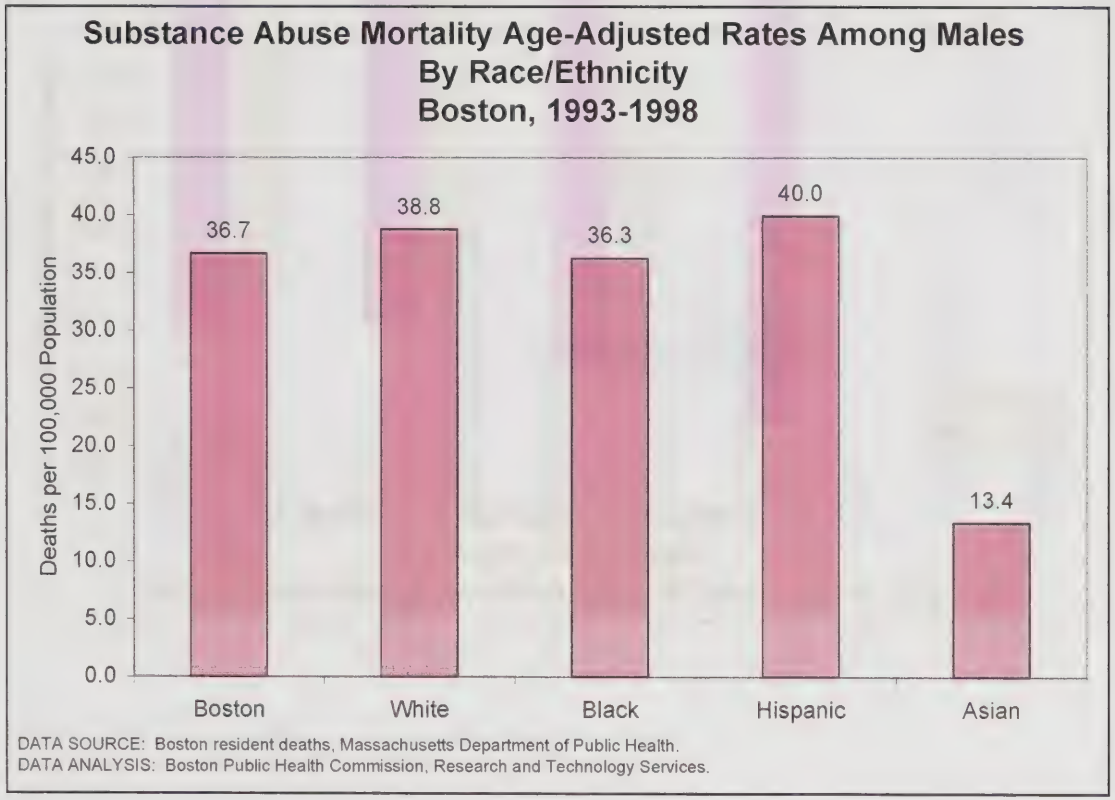


- Five neighborhoods—South Boston, West Roxbury, East Boston, South Dorchester, and Roxbury—had suicide rates among young males ages 15-34 higher than the rate for the city of Boston. Three neighborhoods, Allston/Brighton, North Dorchester, and the Back Bay, had rates which were below the Boston rate.

- South Boston had the highest suicide mortality rate among young males ages 15-34, 2.9 times higher than the overall Boston rate. South Boston had a suicide mortality rate for males ages 15-24 8.3 times higher than the rate for Boston.

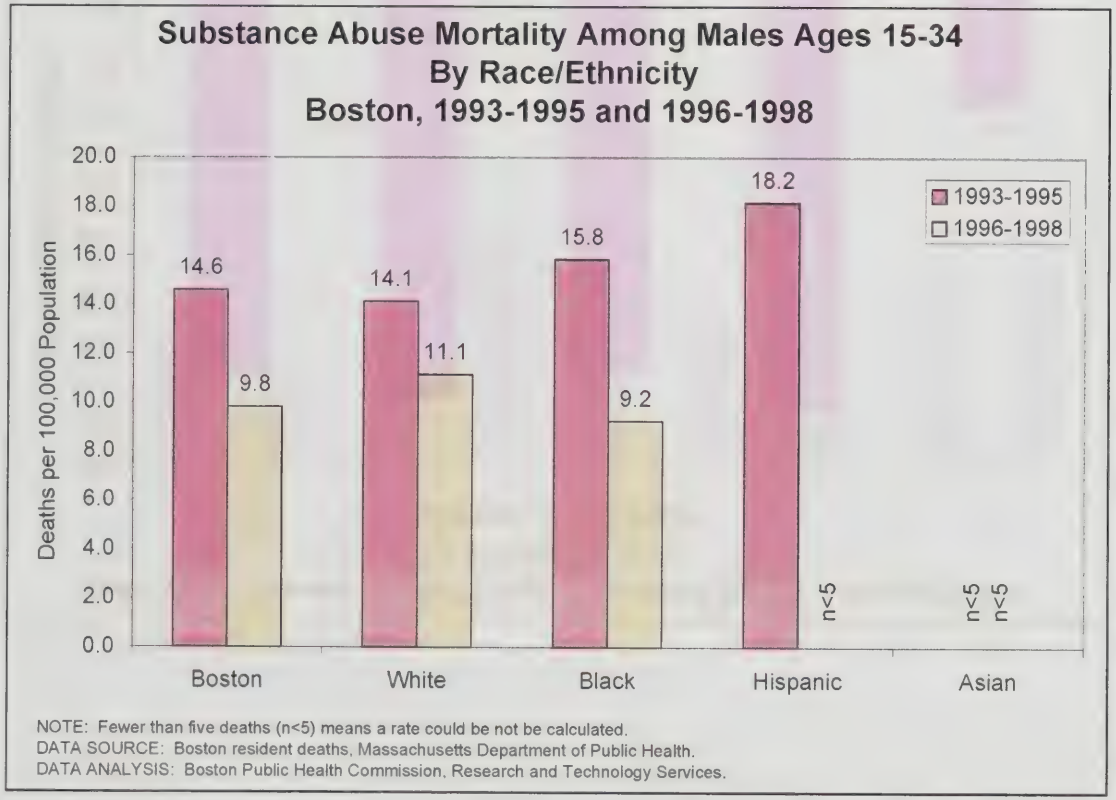
- West Roxbury and East Boston had the second and third highest suicide mortality rates among males ages 15-34, nearly double the overall Boston rate.

- Of all health indicators analyzed in this report, suicide is the only indicator in which West Roxbury was among the neighborhoods with the highest rates.



- The rates of mortality attributable to substance abuse were similar among males for all races/ethnicities except Asians.

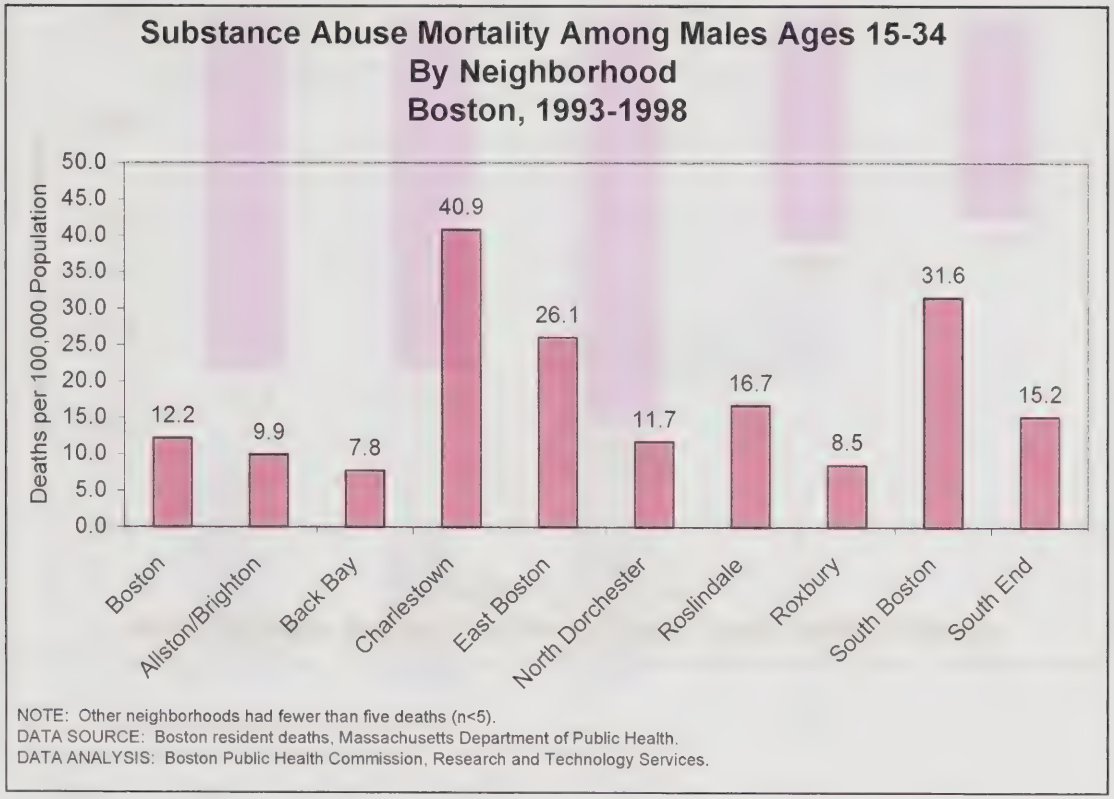
- The substance abuse mortality rate for male Asians was 63.5% below the Boston rate.



- The overall Boston substance abuse mortality rate among males ages 15-34 declined 32.9% between 1993-1995 and 1996-1998. It also declined for most of Boston's races and ethnicities.

- The rate for Black males ages 15-34 declined 41.8% and for White males, 21.3%. The rate for Hispanic males declined from a rate 24.7% higher than Boston and higher than any other race or ethnicity. However, the size of the decline is not calculable since there were too few deaths to calculate a rate.

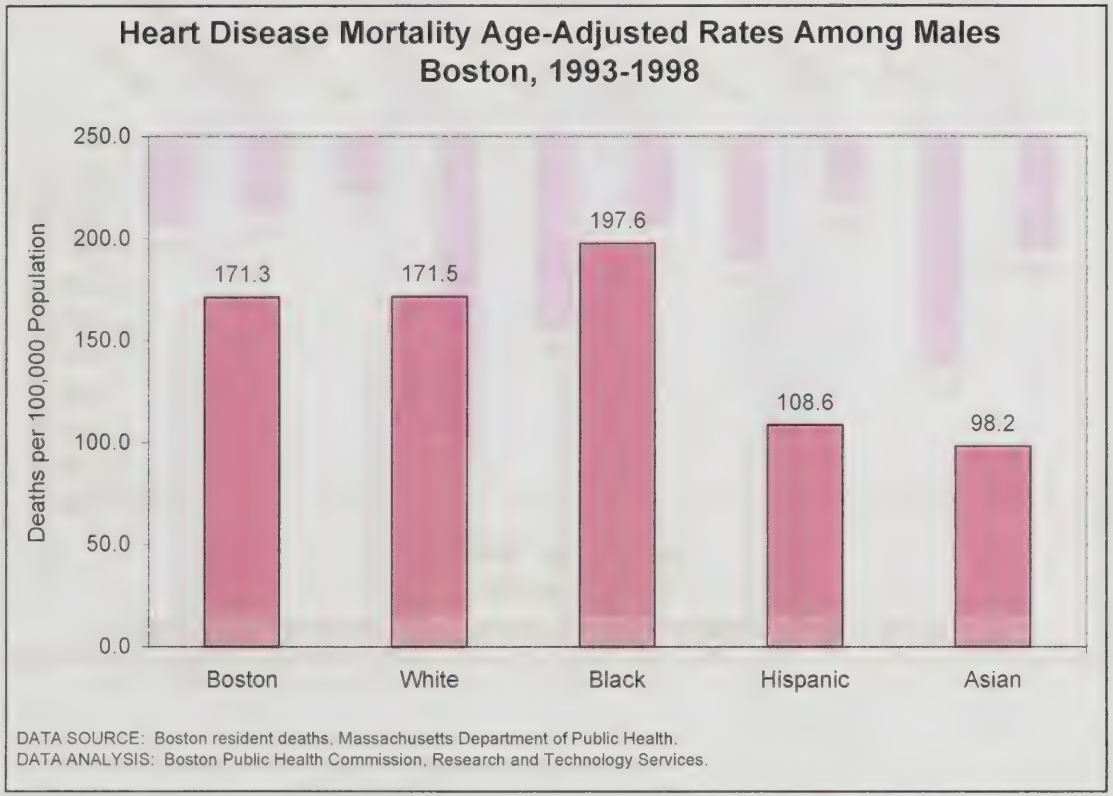
- Among Asians, during both periods, there were too few deaths to calculate a rate.



NOTE: Other neighborhoods had fewer than five deaths (n<5).
DATA SOURCE: Boston resident deaths, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

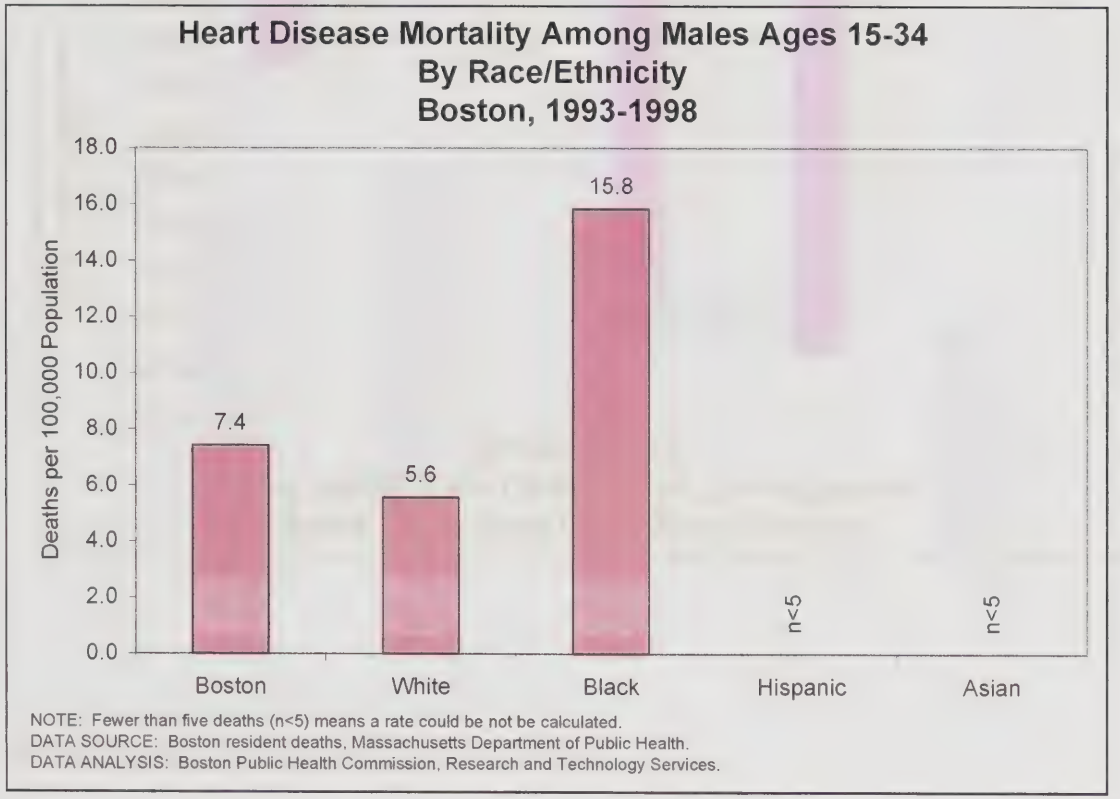
- Five neighborhoods—Charlestown, South Boston, East Boston, Roslindale, and the South End—had substance abuse mortality rates among males ages 15-34 higher than the overall Boston rate. The Charlestown rate, which was the highest of all Boston neighborhoods, was 3.4 times higher than the Boston rate.

- The South Boston rate was 2.6 times higher than the Boston rate, and the East Boston rate 2.1 times higher. The rate for Roslindale was 36.9%, and the rate for South End 24.6% higher than the Boston rate.



- Among all Boston males, the rate of heart disease mortality was highest among Black and White residents, and lowest among Hispanic and Asian residents.

- The heart disease mortality rate among Black males was 15.4% above the Boston overall rate, and among Whites, less than one percent above the Boston overall rate. The rate for Hispanic males was 36.6% below the overall Boston rate, and for Asian males, 42.7% below.

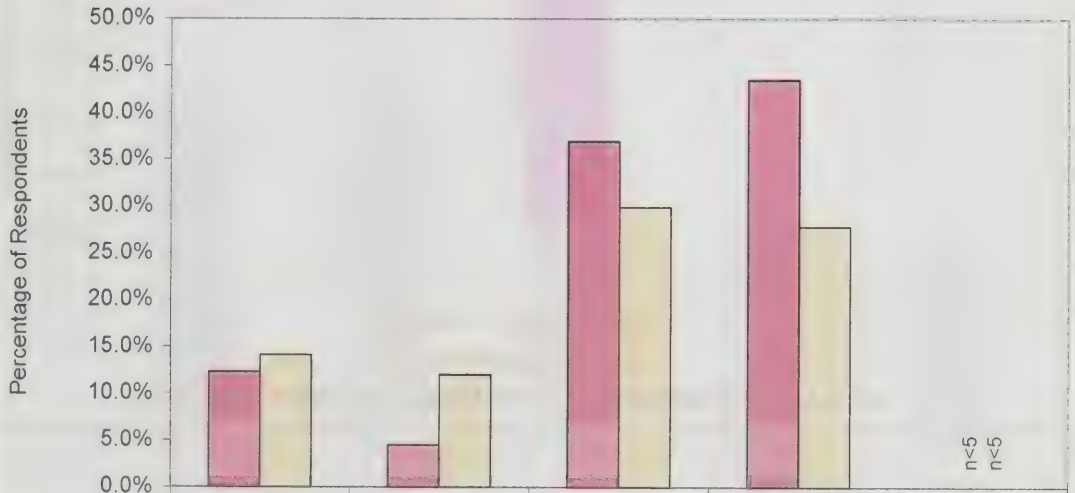


- Among all young males ages 15-34, the rate of heart disease mortality was highest among Black residents, and lowest among Hispanic and Asian residents, who had too few deaths from heart disease to calculate a rate.

- Heart disease mortality among young Black males ages 15-34 was 2.1 times the Boston overall rate. Heart disease mortality among young White males was 24.3% below the Boston overall rate.

ACCESS TO HEALTH CARE

Males Ages 18-24 and Ages 25-34 Who Lack Health Care Coverage by Race/Ethnicity Boston, 1999



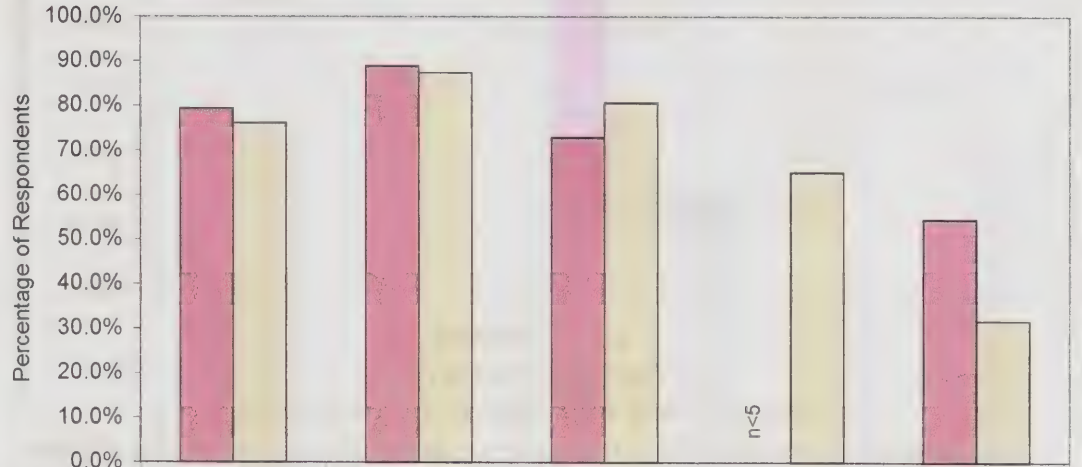
	Boston	White	Black	Hispanic	Asian
Ages 18-24	12.3%	4.5%	36.9%	43.5%	n<5
Ages 25-34	14.1%	12.0%	29.9%	27.8%	n<5

NOTE: Fewer than five events (n<5) means a rate could not be calculated.
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS) Survey, 1999, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

- Among Boston men ages 18-34, those ages 25-34 are more likely to lack health insurance than those ages 18-24. This is not the case for Black men and Hispanic men.

- Among Black and Hispanic males, younger men are more likely to lack health insurance than older men.

Males Ages 18-24 and Ages 25-34 Who Have Employer Health Care Coverage by Race/Ethnicity Boston, 1999

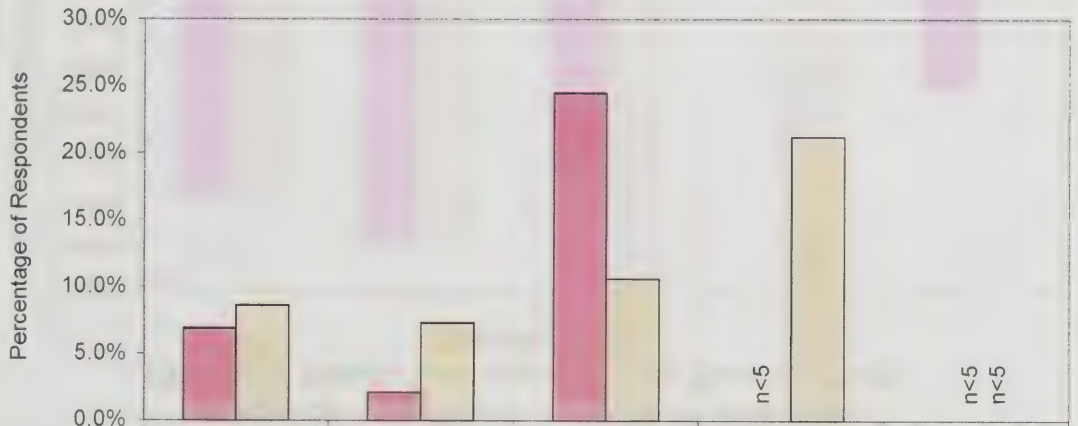


	Boston	White	Black	Hispanic	Asian
18-24	79.4%	88.9%	72.9%	n<5	54.5%
25-34	76.1%	87.4%	80.7%	65.1%	31.8%

NOTE: Fewer than five events (n<5) means a rate could be not be calculated.
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS) Survey, 1999, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

- Boston men ages 18-24 are more likely to have employer health care coverage than men ages 25-34.
- Black and Asian men ages 18-24 are less likely to have employer heath care coverage than White men in the same age group.
- Among men ages 25-34, Black, Hispanic, and Asian men are less likely to have employer health care coverage. Within both age groups, Asians were the least likely.

Males Ages 18-24 and Ages 25-34 Who Experienced a Time When They Could Not Afford to See a Doctor By Race/Ethnicity Boston, 1999



	Boston	White	Black	Hispanic	Asian
18-24	6.9%	2.1%	24.5%	n<5	n<5
25-34	8.6%	7.3%	10.6%	21.2%	n<5

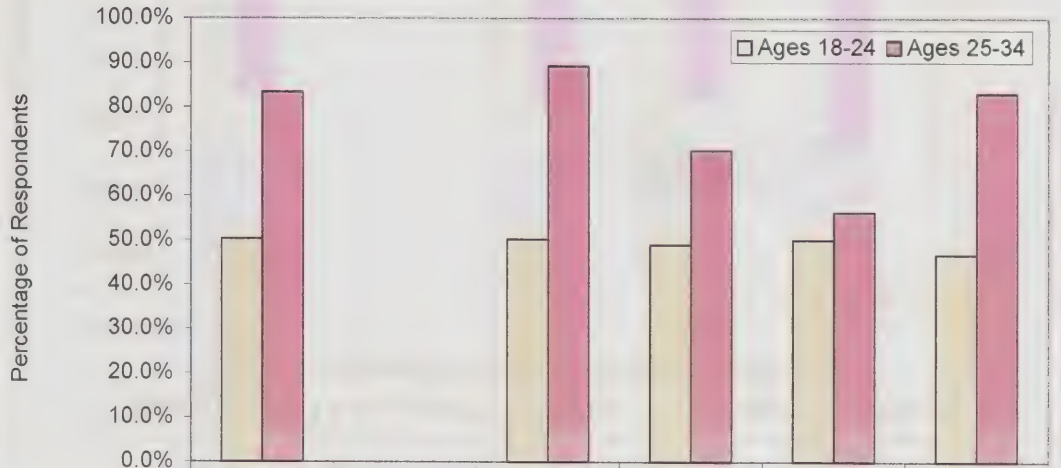
NOTE: Fewer than five (n<5) occurrences means that a rate could not be calculated.
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS) Survey, 1999, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

- Among Boston men ages 18-34, those ages 18-24 are less likely to have experienced a time when they could not afford to see a doctor than those ages 25-34.

- Blacks ages 18-24 are more likely to have experienced a time when they could not afford to see a doctor than Black men ages 25-34.

- Hispanic men ages 25-34 are more likely to have experienced a time when they could not afford to see a doctor than men of other races/ethnicities.

Males Ages 18-24 and 25-34 Who Had at Least One Alcoholic Drink During Past Month By Race/Ethnicity, Boston, 1999



	Boston	White	Black	Hispanic	Asian
Ages 18-24	50.3%	50.2%	49.0%	50.1%	46.8%
Ages 25-34	83.4%	89.3%	70.3%	56.4%	83.2%

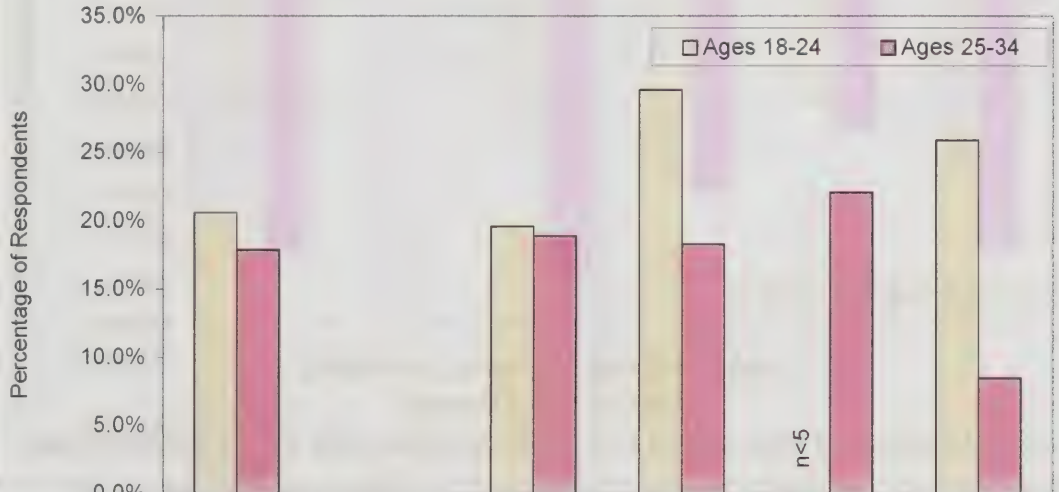
DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS) Survey, 1999, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

- Boston men ages 18-24 are less likely than men ages 25-34 to report having at least one alcoholic drink in the past month.

- For men ages 18-24, the percentage reporting having at least one alcoholic drink in the past month was similar for all races/ethnicities.

- Among men ages 25-34, Whites are more likely to have had an alcoholic drink in the past month than Blacks and Hispanics. Hispanics were the least likely in this age group to have had an alcoholic drink during the past month.

Males Ages 18-24 and 25-34 Who Are Current Smokers By Race/Ethnicity, Boston, 1999



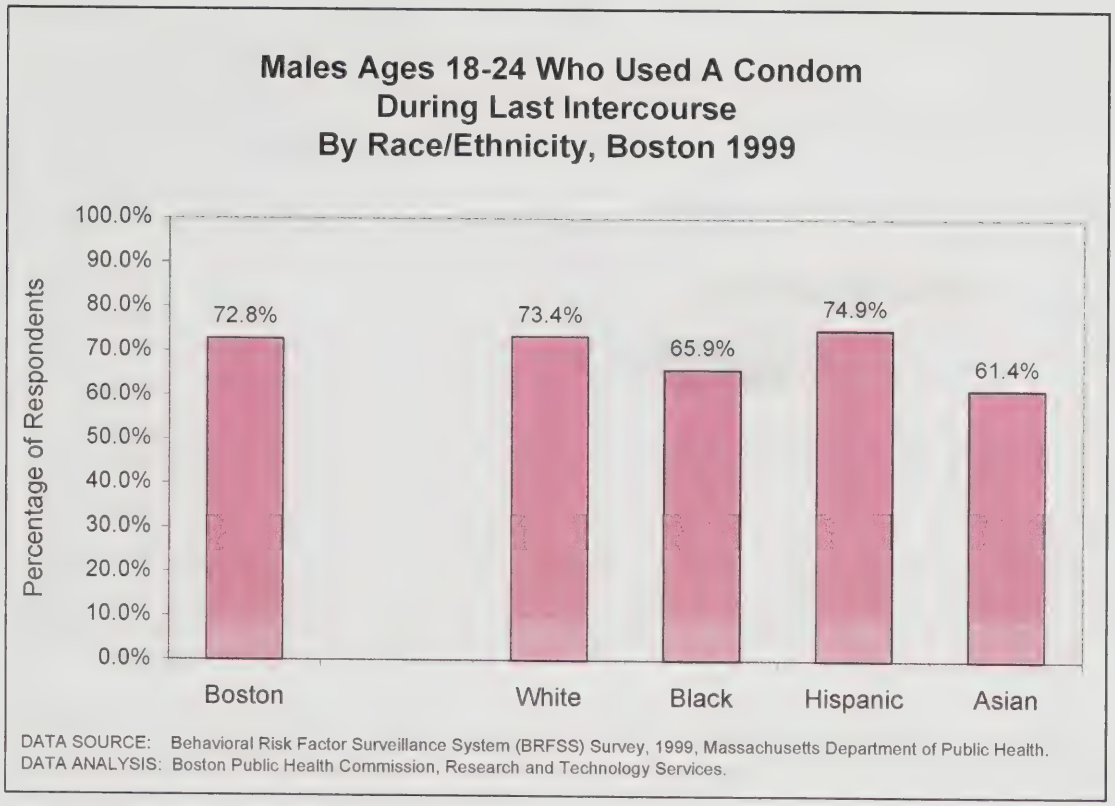
	Boston	White	Black	Hispanic	Asian
Ages 18-24	20.6%	19.6%	29.6%	n<5	25.9%
Ages 25-34	17.9%	18.9%	18.3%	22.1%	8.5%

DATA SOURCE: Behavioral Risk Factor Surveillance System (BRFSS) Survey, 1999, Massachusetts Department of Public Health.
DATA ANALYSIS: Boston Public Health Commission, Research and Technology Services.

- Twenty-one percent of Boston men ages 18-24 and eighteen percent of Boston men ages 25-34 are current smokers.

- Among men ages 18-24 who are current smokers, a greater percentage of Blacks and Asians reported being current smokers.

- Among men ages 25-34, a greater percentage of Hispanics reported being current smokers. For this age group, Asians were the least likely to report being current smokers.



- About three quarters of Boston men ages 18-24 reported using a condom during their last intercourse.

- Among men ages 18-24, Whites and Hispanics were the most likely to use a condom. Blacks and Asians were less likely to have used a condom during their last intercourse.

APPENDIX 1

TECHNICAL NOTES

TECHNICAL NOTES

The Technical Notes provide fuller discussion of some of the technical terms, concepts, and sources used in the *Young Men in Boston 2001: A Health Profile* than can be given in the graphics or in the glossary. Readers can call the Research and Technology Services at (617) 534-4757 on any of the subjects addressed here.

A. Rates
B. Time Period Covered by this Report
C. Population
D. Racial and Ethnic Designations
E. Racial Designations and the 2000 Census
F. Neighborhoods
G. Behavioral Risk Factor Surveillance System (BRFSS)

A. Rates

Three types of rates have been included in the *Young Men in Boston 2001: A Health Profile*: *Crude Rates*, *Age-Specific Rates (ASR)*, and *Age-Adjusted Rates (AARs)*.

A *rate* is a measure of some event, disease, or condition in relation to a unit of population, along with a specification of time.

Age-Specific Rates (ASRs) are used in this report. ASRs take into account the size and age distribution of the population. They enable the reader to compare different groups without being concerned that differences in health status are due to differences in the size of the groups or in the distribution of ages. An ASR is calculated by dividing the number of events among people in an age group by the number of people in that age group. ASRs for deaths and for communicable diseases are usually calculated on the basis of every 100,000 people.

Unless otherwise indicated, the age-specific rates provided in *Young Men in Boston 2001: A Health Profile* are average annual rates. Average annual rates are calculated by dividing the age-specific rates by the number of years in the time period the data represent.

Age-Adjusted Rates (AARs) are also used to present data for comparison among several populations, such as Boston neighborhoods, in which distribution of age can differ considerably. The calculation for AARs takes into account the differences in age distribution and adjusts for them.

The AAR is calculated by applying the age-specific rate in a population (for a specific event such as death) to a standard population (typically, and in this report, the 1940 US standard population). AARs are used in this report for Boston mortality data for overall Boston, for overall Boston mortality data by sex, by race/ethnicity, and by neighborhoods.

B. Time Period Covered by the Report

In general, this report presents data from the years 1994 through 1999. Data for selected indicators may include a range of years or one year only, such as 1999. Boston-specific mortality and selected morbidity data are presented for one year only, for part of the time span, or for the entire time span, either in aggregated form or year-by-year.

The selection of time periods to use depends largely on the availability and adequacy of the data. In analyzing subgroups within the Boston population, there must be enough events or occurrences, such as deaths, to provide interpretable rates. The BPHC Research and Technology Services does not calculate rates for fewer than five occurrences. The notation "n<5" in charts indicates there were fewer than five occurrences of a heath condition, and therefore a rate was not calculable.

C. Population

Health status reports often use population statistics for analyzing health data. These population statistics may be drawn from two sources. The first is the census of the population taken every ten years by the federal government, a literal count of all people living in the United States. The second is estimates of the population made by the US Census Bureau in the intervening years.

Each source has its own advantages, and there are distinct reasons for choosing each one. The census provides the best available actual count of the population. Another important strength of the census is that it presents data to the level of small areas called census tracts, each of which has only a few thousand residents. Census tracts can be combined to produce neighborhood-level analyses.

However, while the 1990 census is the best estimate of the population for the early years included in this report, with each passing year it becomes more remote from the population it is being used to represent and therefore less useful. Changes in the population in the years following the census cannot be taken into account when using the census data.

Population projections, or estimates, of the population, which are often used to compensate for this problem, are made by the Census Bureau using sophisticated statistical methods. They are designed to estimate the changes which are occurring in the population between the years of the actual censuses. And yet, for the purposes of this report, estimates of population changes between census years have significant drawbacks. They do not account for changes in the racial composition of a community, and they do not permit neighborhood-level analyses. Perhaps most importantly, even small errors in the accuracy of projections for neighborhoods or other population subgroups can result in large distortions in their rates.

Therefore, the BPHC bases its reports on data from the censuses and not on estimates of the population. Furthermore, it uses the Modified Age-Race-Sex File for Boston census tracts, produced by the US Census Bureau to enable reporting on Hispanics as a separate category. Readers should note that the Massachusetts Department of Public Health uses population estimates from Massachusetts Institute for Social and Economic Research (MISER) for reports on data for the years after 1990, and the federal government frequently uses population estimates in its reports, so the rates in this report may not always be comparable to those published by MDPH or the federal government.

In years like 2001, when data from the most recent census (2000) are still being analyzed and not all results have been published, it is sometimes necessary to use the previous census (1990). Statistics from the 2000 census providing age breakdowns, sex, and race or ethnicity are not yet available at the time of publication; therefore rates in this report that require population data (such as age-adjusted mortality rates) use data from the 1990 census.

To provide data on people of Hispanic ethnicity, who may be of any race, this report uses the 1990 Modified Age-Race-Sex File for Boston census tracts, produced by the Bureau of the Census, for denominators for rate calculations that require population data. This avoids the double-counting which would result if Hispanics were included in the White and Black racial categories as well as in the Hispanic categories.

D. Racial and Ethnic Designations

Racial and ethnic designations are derived from the source of the data, including the US census, birth and death data from the Massachusetts Department of Public Health, and others. All racial or ethnic designations except death certificates are self-reported. In considering the racial or ethnic designations used in this report for Boston-specific data, several things should be kept in mind: (1) The concept of race has different meanings in different cultures (2). Race is not a biological but a social construction. (3) The meanings of racial designations—White, Black, Asian/Pacific Islander—are subject to historical, cultural, and political forces. (4) Racial designations can be notably inaccurate in describing what they are called upon to describe. The term Black, for example, includes a variety of people who would describe themselves as African-American, African, Caribbean, or Haitian.

In the charts which present data by race and ethnicity or in the text which discusses health problems among racial and ethnic populations, it should be kept in mind that, as the Centers for Disease Control and Prevention (CDC) has said, "race and ethnicity are not risk factors [for disease]—they are markers used to better understand risk factors." Race is often a proxy for such factors as socioeconomic status, inadequate access to health care, and racial discrimination. Information on race and ethnicity is included in this report because it can assist public health efforts in recognizing disparities between groups in health outcomes.

Boston-specific data in this report are generally presented for each racial and ethnic subgroup when data are available and numbers are large enough to allow calculation of percentages or reliable rates. Some charts present data only for the largest racial and ethnic groups, such as non-Hispanic Whites, non-Hispanic Blacks, and Hispanics. Few sources provide data in large enough numbers for smaller groups such as the many ethnicities included in the category "Asian/Pacific Islander."

The collection of racial and ethnic data varies with the data source. Some sources rely on observation and others on self-report. Race and ethnicity on death certificates are reported by the funeral director based on information provided by a relative or friend if available, while birth certificates are based on self-report by the mother.

Since Hispanics can be of any race, the federal and state data sources often report data for Blacks and Whites, including Hispanics in those categories. However, in the charts and in the discussions provided in the *Young Men in Boston 2001: A Health Profile*, where references are made to races/ethnicities, the Boston-specific data do not include Hispanics in the categories "Black" and "White."

E. Racial Designations and the 2000 Census

This report uses racial designations, or categories, used in the 1990 census. The racial designations used in the 2000 census differ from the designations used in the 1990 census and in the census documents based on it, like the 1990 Modified Age-Race-Sex File for Boston census tracts.

For a discussion of this issue and its effect on this report, see *Census 2000 and the Changing Concepts of Race*, in Demographics, the *Health of Boston 2001,* recently published. See also Technical Notes and the Glossary.

F. Neighborhoods

Census tracts are so small that there are often not a sufficient number of health-related events—such as deaths—to calculate reliable rates, particularly for individual years. Therefore, census tracts are combined into neighborhoods for the presentation of the mortality data.

Some of Boston's neighborhoods are clearly defined. West Roxbury, for example, is bordered by the West Roxbury Parkway, the Stony Brook Reservation, and Dedham. The boundaries of most neighborhoods are less distinct for historical, political, or geographic reasons.

A goal for this report was to select geographic areas that were small enough to show the variation of health patterns throughout the city while being large enough to be statistically reliable. Neighborhood definitions were determined in consultation with residents, health care providers, and advocates throughout Boston. Where neighborhood definitions vary by data source, they are noted in the text. The definitions are the same as those used in *Health of Boston 2001* and other BPHC reports.

G. Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System is a survey developed by the Centers for Disease Control and Prevention. Participants are enrolled through random-digit-dialing and include all non-institutionalized adults ages 18 years and older in households with telephones. This survey is conducted in all 50 states as a collaboration between the CDC and State Health Departments.

The Behavioral Risk Factor Surveillance Survey includes core CDC questions and any additional questions requested by the state. The BRFSS is an annual survey; however, in order to control for seasonal bias, continuous monthly sampling is conducted. In 1999, additional surveys were administered to Boston residents. The analysis is performed for six regional clusters within Boston.

The survey includes questions which address the following areas of health: cancer screening, alcohol use, mental health, health status, elder health, quality of life, heart disease, chronic disease, access to care, immunization, injury control, smoking, violence, disability, oral health, and HIV/AIDS.

The 1999 Behavioral Risk Factor Surveillance Survey included a sample size of 2731 people. Of these 2731 people, 58.5% or 1598 were female. The racial/ethnic distribution of the respondents included 1590 (59.3%) White, 543 (20.3%) Black, 380 (14.2%) Hispanic, 119 (4.4%) Asian, and 49 (1.8%) Unknown.

APPENDIX 2

DATA SOURCES

DATA SOURCES

Acute care hospital case mix 1997-1998 [data file]. Boston: Massachusetts Division of Health Care Finance and Policy.

Acute care hospital discharge data [data file of 1994, 1995, 1996, 1997, 1998 hospitalizations]. Boston: Massachusetts Health Data Consortium, Inc.

Behavioral Risk Factor Survey, 1994-1999. Behavioral Risk Factor Surveillance System (BRFSS). Boston: Massachusetts Department of Public Health.

Boston resident deaths [data file, 1993-1998]. Boston: Massachusetts Department of Public Health, Bureau of Health Statistics and Research and Evaluation (BHSR), Registry of Vital Records and Statistics.

Population data, 1990. Modified Age-Race-Sex (MARS) file for Boston census tracts [data file], 1990. Washington: US Department of Commerce, Bureau of the Census.

Selected STDs for Boston Report 1990-1999. Boston: Massachusetts Department of Public Health, Sexually Transmitted Disease Division.

Summary Tape File 3A, 1990 [provides estimates based on an eleven percent sample of the population]. Boston: US Department of Commerce, Bureau of the Census.

Weapon-related injury data, 1994-1999. Boston: Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System.

APPENDIX 3

GLOSSARY

GLOSSARY

The glossary includes explanations of terms, concepts, and sources used in this publication. Readers can call the Research and Technology Services at (617) 534-4757 for more information on any of the subjects addressed here.

To help the reader compare the data presented for specific health indicators in this report to data from other sources, the definitions provided below include the codes used to classify causes of hospitalization or death. The hospitalization codes are from the Diagnostic Related Grouping (DRG), based on version 8 of the Federal Grouper. The cause-of-death codes are from the International Classification of Diseases, 9th Revision, Clinical Modification, 4th Edition (ICD-9-CM), a product of the US Department of Health and Human Services.

Any terms used in a definition that are themselves defined in this section are in **boldface.**

AAR: See **Age-Adjusted Mortality Rate**

Acquired Immune Deficiency Syndrome (AIDS): See **HIV/AIDS**.

Adolescent Births: Births to females 10 to 19 years of age.

African American: All persons self-identified as being born in the US and of African descent.

Age-Adjusted Mortality Rate (AAR): The age-adjusted mortality rate is calculated by applying the **age-specific mortality rates** in a population to a standard population (typically, and in this report, the 1940 US population). The age-adjusted rate of one area or group can be compared to the age-adjusted rate of another area or group with confidence that differences in the rates of the two areas or groups do not stem from differences in the age structure of their populations.

Age-Specific Mortality Rate (ASR): The number of deaths per year in a given age group per 100,000 people in that age group. See *Technical Notes* for further information.

Alcohol-Related Deaths: Causes of death directly related to alcohol use/abuse, such as liver disease attributed to alcohol consumption, accidental alcohol overdose, etc. This category does *not* include deaths indirectly due to alcohol use, such as deaths due to injuries occurring while intoxicated or deaths caused by another person who was intoxicated. For pre-1999 data in this report, ICD-9 codes 291, 303, 305.0, 357.5, 425.5, 535.3, 571.0-571.3, 790.3, E860.

Asian: All persons self-identified as Asian or Pacific Islander (e.g., Chinese, Japanese, Hawaiians, Cambodians, Vietnamese, Asian Indians, Filipinos) who do not identify themselves as Hispanic.

Asthma and Bronchitis: Asthma is a chronic inflammatory condition defined by sudden periodic attacks of difficulty in breathing accompanied by wheezing caused by a spasm of the bronchial tubes. Bronchitis refers to inflammation of the mucous membrane of the bronchial tubes. DRG 96-98.

Behavioral Risk Factor Surveillance System (BRFSS): A random telephone survey of Massachusetts adults ages 18 years and older. The survey is sponsored by the Centers for Disease Control and Prevention (CDC) and is conducted annually in all 50 states. The BRFSS collects information regarding various health related issues, such as behavior, attitudes, knowledge, access to health care, and opinions on health policy issues. The responses to the survey provide important information regarding the prevalence of risk factors that are responsible for causing premature death, illness, and disability among Massachusetts residents.

Black: All persons self-identified as Black (e.g., African-Americans, Haitians, West Indians) who do not identify themselves as Hispanic. (See Non-Hispanic Black.)

Cardiovascular Disease (CVD): A group of diseases that affect the heart including high blood pressure, coronary heart disease, stroke, congestive heart failure, and congenital heart defects. For pre-1999 data in this report, ICD-9 codes 390-398, 402, 404, 410-429, 430-434, 436-438, 440.

Cellulitis: An infection of skin or connective tissues (an infection in or close to the skin) is usually controlled by body defense mechanisms. If inflammation spreads through the tissues, however, the process is called **cellulitis**. DRG 277-279

Census 2000: The count of the population undertaken by the Census Bureau in 2000. At the time of publication of this report, national, state, and local numbers have been released. Data currently available does not provide the full details on age or sex distribution of the population.

Chlamydia: A sexually transmitted disease caused by any member of the genus *Chlamydia*.

Death Rate: The number of deaths per year per 100,000 population.

Demographics: The statistical study of characteristics of human populations and of population distributions such as age, sex, and race/ethnicity.

Diabetes: A chronic metabolic disease characterized by inadequate insulin production by the pancreas. ICD-9-CM codes 250.0-250.9.

Drug-Related Deaths: Causes of death related to the use of drugs other than alcohol and tobacco, including direct physiological causes as well as some accidental deaths in which drug use/abuse is involved. Does *not* include deaths indirectly due to drug use, such as death due to injuries occurring while under the influence of drugs or deaths caused by another person under the influence of drugs. For pre-1999 data in this report, ICD-9 codes 292, 304, 305.2-305.9, E850-E858, E950.0-E950.5, E962.0, E980.0-E980.5.

Gastroenteritis, Esophagitis, and Miscellaneous Digestive Disorders: Infection of the mucous membranes of the stomach and intestine.

Gonorrhea: A contagious catarrhal inflammation of the genital mucous membrane, transmitted chiefly by sexual intercourse and due to *Neisseria gonorrhoeae;* may involve the lower or upper genital tract, especially the urethra, endocervix, and Fallopian tubes, or spread to the peritoneum and rarely to the heart, joints, or other structures by way of the bloodstream.

Heart Disease: A group of diseases affecting the heart, including valve and conductive disorders as well as hypertensive diseases. For pre-1999 data in this report ICD-9 codes 390-398, 402, 404, 410-429.

Hispanic: Includes people of any race (Asian, Black, White, or Other) self-identified as Hispanic or Latino, such as Puerto Rican, Mexican, Cuban, Spanish, and Dominican.

HIV/AIDS: The Human Immunodeficiency Virus (HIV) infection, which leads to Acquired Immune Deficiency Syndrome (AIDS) or other HIV infections. For pre-1999 data in this report ICD-9 codes 042-044.

HIV+ or HIV Infection: Having tested positive for the antibodies to Human Immunodeficiency Virus (HIV), meaning that one is infected with the virus, with or without major related conditions. DRG 700-702, 704-708, 710-714.

Homicide: A death intentionally caused by a person other than the deceased. For pre-1999 data in this report, ICD-9 codes E960-E969.

Hospitalization: A patient's continuous stay of one night or more in the hospital for observation, care, diagnosis, or treatment before being released by the hospital, or before death.

Human Immunodeficiency Virus (HIV): The virus that is responsible for causing AIDS.

ICD-9 Codes: Codes designed for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations for data storage and retrieval. International Classification of Disease Codes, 9th Revision, Clinical Modification (ICD-9-CM) is based on the official version of the World Health Organization's 9th Revision, International Classification of Diseases (ICD-9). ICD-9 and ICD-9-CM codes were used to classify data from 1979 to 1998. ICD-9 classification has been replaced by ICD-10 classification.

Incidence: The number of reported new cases of a particular disease over a period of time and in relation to the population in which it occurs.

Injury: Injury deaths include five categories: **homicides, suicides, motor vehicle-related injuries,** (other) **unintentional injuries,** and **"undetermined"** injuries (for which it was not determined on the death certificate whether the injury was intentional). The latter two categories are frequently presented together in this report. The determinations of intent are for purposes of medical record-keeping only. Each chart that includes data on injury deaths specifies exactly which types of injuries are included. For hospitalization-related charts and text in this report, injury is an aggregation of DRGs 280-282, MDC21, 22, and 24.

Mortality: The relative frequency of deaths in a specific time period; death rate.

N<5: A notation used on charts in the *Young Men in Boston 2001: A Health Profile* to indicate that in this health indicator there were fewer than five occurrences (for example, births, deaths, new cases) of a disease, and that a rate could not be calculated. See Technical Notes.

Neighborhood: One of 16 distinct geographical areas in Boston.

Non-Hispanic Black: All persons self-identified as Black (e.g. African-Americans, Haitians, West Indians) who do not identify themselves as Hispanic.

Non-Hispanic White: All persons self-identified as White who do not identify themselves as Hispanic.

Pneumonia/Pleurisy: Bacterial or viral infection of the lungs and inflammation of the pleura, the membrane that covers both lungs. DRG 89-91.

Psychoses: Acute mental disorders characterized by loss of contact with reality and personality disintegration. DRG.430

Sexually Transmitted Disease: Infection spread by transfer of organisms from person to person during sexual contact.

Standard Population: A national estimate of the population, in which the age, race, and sex distribution are known, resulting in a set of population weights used to calculate age-adjusted mortality rates. *Standard population* is not to be confused with population numbers from any particular census. In this report, the standard population used to calculate age-adjusted mortality rates is the year 1940 US standard population.

Substance Use and Abuse: Use or overuse of ingested substances both legal (such as alcohol) and illegal (such as cocaine). For pre-1999 alcohol related data in this report, ICD-9 codes 291, 303, 305.0, 357.5, 425.5, 535.3, 571.0-571.3, 790.3, E860. For pre-1999 drug-related data in this report, ICD-9 codes 292, 304, 305.2-305.9, E850-E858, E950.0-E950.5, E962.0, E980.0-E980.5.

Suicide: The act of taking one's own life voluntarily and intentionally. ICD-9-CM codes E950.0-E959.9.

Syphilis: An acute and chronic infectious disease caused by *Treponema pallidum* and transmitted by direct contact, usually through sexual intercourse. After an incubation period of 12 to 30 days, the first symptom is a chancre, followed by slight fever and other constitutional symptoms.

Unintentional Injury: An injury that was accidental. ICD-9-CM codes E800.0-E809.9, E830.0-E949.9, E980.0-E989.9. The ICD-9-CM codes used by the Healthy People 2010 committee, and therefore used for the Boston rates for comparison with the Healthy People 2010 goals, are slightly different. They are E800.0-E949.9.

White: All persons self-identified as White who do not identify themselves as Hispanic. (See non-Hispanic White.)

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